The Superguide

a handbook for
supervising allied health professionals

NSW GOVERNMENT

HETI HEALTH EDUCATION & TRAINING

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Forewords

As an outcome of the Director-General's Governance Review on the future directions for NSW Health completed in October 2011, CETI has been restructured to become the Health Education and Training Institute (HETI).

HETI has an enhanced focus including clinical and non-clinical education and training. Responsibilities include management development and leadership programs for the system in addition to CETI's existing focus on postgraduate services including undergraduate and vocational training. HETI will establish itself as a national leader in people development within the health sector in NSW.

Allied health professionals are recognised as essential members of the multidisciplinary team playing a critical role in prevention, treatment and management of complex co-morbidities across the continuum of care, reducing the impact of chronic disease and increasing patients' quality of life.

Effective supervision is a critical ingredient to ensuring patient safety and promoting professional development of clinicians. Supervision sessions provide a platform for critical reflection, development of critical reasoning and identification of further learning opportunities. Supervision has benefits to health care organisations by enhancing job satisfaction of both supervisees and supervisors which increases staff retention.

HETI is delighted to present the second edition of *The Superguide: a handbook for supervising allied health professionals.* This document will continue to enrich the quality of supervision being provided by allied health supervisors in NSW.

Heather Gray, HETI Chief Executive, 2012 - 2014

This handbook is a welcome resource to the many dedicated allied health professionals working in the NSW Health system. It is recognised that while the 23 allied health professions are unique, the importance of supervision is common to us all. Supervisors are a vital front line resource and have a critical role in developing confident and competent allied health clinicians, promoting excellence in clinical practice, and ensuring patient safety and quality of care. As health professionals we have a responsibility to not only monitor our own practice but also to share our experience with others. Being a supervisor is one of the ways allied health professionals can meet this responsibility. Supervision provided in a positive and supportive environment enables clinicians to excel in clinical practice. Experienced clinicians also have a role in providing constructive feedback and supporting supervisors. As role models, supervisors should "practice what they preach" by also receiving supervision. This assists clinicians to embed a culture of lifelong learning and reflective practice from the very beginning of their careers. While this guide cannot possibly cover everything there is to know about clinical supervision, we hope it will "reinvigorate the conversation" about supervision among allied health professionals. We encourage clinicians to utilise this guide by applying it to their individual professional context to improve the quality of clinical supervision.

Brenda McLeod, Chief Allied Health Officer, NSW Ministry of Health

Acknowledgements

This handbook has been adapted from the original content and format of *The Superguide – a handbook for supervising doctors in training*, 1st edition, November 2010, written by Craig Bingham and Dr Ros Crampton.

Following an initial review of The Superguide content by five members* of the NSW Allied Health Directors Network, *The Superguide: a handbook for supervising allied health professionals* was written by **The Superguide Steering Committee**:

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A list of key contributors is provided on page 85.

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About this handbook

HETI has produced this guide in response to the request from many involved in supervising allied health professionals for a simple and practical guide to clinical supervision. Along with the supportive functions of supervision, it is also acknowledged that in practice many supervisors are also involved in teaching and training of staff to facilitate professional development and competence in clinical practice. This guide therefore also provides information to equip supervisors with practical strategies to facilitate adult learning and the acquisition of skills and knowledge.

This handbook is not a policy document. It gives tips and suggestions based on the published evidence of what makes good supervision and the knowledge of many experienced supervisors in New South Wales.

It provides information about:

- supervising allied health professionals in ways that contribute to the safety and better care of patients
- effective methods of contributing to the education, welfare and professional development of allied health professionals

It is acknowledged that supervision terminology and requirements are varied across the allied health disciplines. In addition, it is important to recognise that each discipline has different requirements for registration and continuing professional development. There are sections of this guide which are more applicable to the supervision of junior allied health professionals, however, whilst learning needs change with experience of individual clinicians, it is hoped that the principles of this guide can be applied to all allied health professionals throughout their careers.

This document should be used in conjunction with existing discipline specific supervision requirements, Local Health District* supervision and other policies. It will be reviewed regularly to ensure that information made available to supervisors is current and useful.

This guide, updates and other useful resources are available on the website of the Health Education and Training Institute: www.heti.nsw.gov.au

NSW Health supervision policies can be found at www.health.nsw.gov.au

* Please note the term Local Health District used in the context of this document includes speciality health and hospital networks such as St Vincent's Health Network, Forensic Mental Health Specialty Network and Sydney Children's Hospitals Specialty Network.

Allied health in NSW Health

Allied health professionals:

- are tertiary qualified

- hold relevant registration, licence or accreditation to practice

- provide a range of therapeutic and diagnostic services in either the public or private health care sector

- apply their skills and knowledge holistically to restore and maintain optimal physical, sensory, psychological, cognitive and social function

- use clinical reasoning skills in working directly with clients to prevent and/or minimise disability, restore and optimise function on an individual basis

- work as part of a multidisciplinary team

- are 'allied' or aligned to each other and other members of the health professional workforce, their clients, the client's family, carers and community working across the health system.

NSW Health allied health professionals*

Art Therapist	Nuclear Medicine Technologist	Psychologist
Audiologist	Occupational Therapist	Radiation Therapist
Counsellor	Orthoptist	Radiographer
Dietitian	Orthotist & Prosthetist	Sexual Assault Counsellor
Diversional Therapist	Pharmacist	Social Worker
Exercise Physiologist	Physiotherapist	Speech Pathologist
Genetic Counsellor	Play Therapist/Child Life Therapist	Welfare Officer
Music Therapist	Podiatrist	

* Information provided by Brenda McLeod, Chief Allied Health Officer, Workforce Development and Innovation Branch, NSW Ministry of Health.

The supersummary

Key messages

- The quality of supervision makes a difference to the quality of safe patient care.
- When establishing a relationship between a supervisor and a supervisee, it is important to ensure from the very beginning that both parties have clear expectations of the process.
- Supervision provides an ideal forum to promote a culture of life-long learning.
- Supervisees must be active participants in the supervision process.
- Supervisors should be aware of adult learning principles and learning styles.
- Contributing to the professional development of allied health professionals can be one of the most rewarding parts of a senior clinician's job.

Supervision facilitates

- acquisition of skills and knowledge
- reflective practice
- development of professionalism
- confidence and competence in clinical practice
- professional growth and development. ▶ **p7**

Setting expectations

When establishing a relationship between a supervisee and a supervisor, it is important to ensure from the very beginning that both parties have clear expectations of the process. ▶ **p16**

The A-rated clinical supervisor

- Available
- Approachable
- Able (as both clinician and teacher)
- Active (finds the gaps)

What makes an effective clinical supervisor? ▶ **p27**

Purpose of supervision

- High quality and safe patient care and treatment
- Accountable decision making in clinical practice
- Facilitation of learning and professional development
- Promotion of staff well being

Learning plan and SMART goals

Every clinician should have an individual learning plan with specific learning objectives detailing what it is they are working towards. ▶ **p19**

Reflective practice

"A continuous process that involves thoughtfully considering one's own experiences and applying knowledge to practice" (Schön 1983). ▶**p21**

Patient safety comes first

Patient safety is a core responsibility of all clinical staff that cannot be delegated. ▶ **p30**

Knowing your supervisee's competence level ▶ **p31**

Unconsciously incompetent:
The staff member does not know what they do not know.

Danger at this stage:
An inadequately supervised staff member may unwittingly do harm.

Response:
Supervise closely (hands-on), and address the knowledge gaps of the staff member.

Consciously incompetent:
The staff member knows that they do not know.

Danger at this stage:
Staff members may avoid situations that test their incompetence.

Response:
Supervise closely (hands-on), and encourage the staff member to overcome their inexperience.

Unconsciously competent:
The staff member can perform the task competently with practised ease.

Response:
The staff member no longer needs supervision in this task. Get them involved in teaching it to others.

Consciously competent:
The staff member can, with thought, perform the task competently.

Danger at this stage:
Atypical circumstances or pressure may cause the staff member to fail despite previous success.

Response:
Supervise with hands off, provide praise, recognition, opportunities to practise.

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Active supervision

Active supervision occurs when the supervisor is sufficiently engaged and vigilant to support staff when they need help, whether or not a request for help is made. Active supervision acknowledges that some staff, or all staff in some situations, are "unconsciously incompetent" – that is, they do not know what they do not know, and will not always recognise situations that are beyond their current abilities where patient safety may be at risk. ▶ **p31**

Feedback

Feedback is one of the most important things that supervisees receive from their supervisors. ▶ **p34**

Clinical teaching aims to:

- improve knowledge and skills
- integrate theory into practice
- develop self awareness
- facilitate reflection on practice. ▶ **p39**

Promoting a culture of life-long learning

- Life-long learning encompasses not only structured learning through education but also learning through personal experience.
- Supervisors should encourage supervisees to undertake self-directed learning activities. ▶ **p40**

Facilitating learning

When facilitating adult learning, it is important to consider principles of adult learning and different learning styles. Adult learners need to be respected, valued and acknowledged for their past experience and have an opportunity to apply this experience to their current learning. ▶ **p41**

Ten top tips for the teaching supervisor ▶ **p44**

Importance of handover

- Failures in handover have been identified as a major preventable cause of patient harm.
- Allied health professionals need to be encouraged to value the task of handover and to see it as an essential and integral part of their daily work. ▶ **p48**

Developing skills in teaching and education

- Skills in clinical education must be learned like everything else in clinical practice.
- Years of experience in clinical practice does not in itself make a great clinical teacher. ▶ **p57**

Fostering interprofessional collaborative practice

As a supervisor, consider fostering interprofessional collaborative practice by:

- facilitating interdisciplinary group supervision
- inviting relevant disciplines to participate in seminars, workshops, ward rounds, and clinical reviews
- supporting interdisciplinary placement programs
- encouraging supervisees to enquire about the roles and responsibilities of other professional disciplines. ▶ **p59**

Managing a clinician in difficulty

Seek advice without delay: prevention is better than cure. ▶**p68**

See the contents list for more ▶ p1

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Part one

What is supervision?

Supervision is a 'relationship based activity which enables practitioners to reflect upon the connection between task and process within their work. It provides a supportive, administrative and development context within which responsiveness to clients and accountable decision making can be sustained'. (Davies 2000, p.204)

Introduction: the purpose of clinical supervision

The purpose of clinical supervision is to ensure:

- delivery of high quality patient care and treatment through accountable decision making and clinical practice
- facilitation of learning and professional development
- promotion of staff wellbeing by provision of support.

Clinical supervision is considered a vital part of modern, effective health care systems (Milne 2007). Providing effective clinical supervisory support to allied health professionals enhances quality, safety and productivity and improves competence and confidence in clinical practice (Country Health SA 2009; Smith & Pilling 2008; The Chartered Society of Physiotherapy 2005).

Supervision facilitates:

- acquisition of skills and knowledge
- reflective practice
- development of professionalism
- confidence and competence in clinical practice
- professional growth and development.

The *Special Commission of Inquiry into the NSW Acute Public Health System* highlighted the link between patient safety and the availability of supervision for junior clinical staff (Garling 2008). While good supervision reduces errors and improves the quality of patient care, inadequate supervision is a contributing factor in critical incidents with poor patient outcomes (Kirk, Eaton & Auty 2000).

Supervision of clinicians has been identified as a national priority by Health Workforce Australia (HWA) as evidenced through the development of a National Clinical Supervision Support Framework and the Clinical Supervision Support Program (HWA 2011a; HWA 2011b).

Contributing to the professional development of allied health professionals can be one of the most rewarding parts of a senior clinician's job. Well-supported allied health professionals who have access to supervision report improved job satisfaction, which can lead to improved staff retention rates (Smith & Pilling 2008).

The importance of active clinical supervision cannot be underestimated, yet many supervisors feel that they do not always have the time or the skills to provide it. This guide is focused on providing advice to improve the effectiveness and educational value of clinical supervision for allied health professionals in NSW.

Functions of supervision

Supervision comprises a number of different functions. Kadushin's model of supervision outlined three functions; educational, supportive and administrative (Kadushin 1976). These functions have been further defined by Proctor (1987) as formative, restorative and normative, describing them in terms of an interactive framework for clinical supervision, suggesting that all three functions should be overlapping and flexible (Driscoll 2007).

Function

Educational (Formative)	Educational development of each worker in a manner that enhances their full potential. ● Providing knowledge and skills ● Developing self-awareness ● Reflecting on practice ● Integrating theory into practice ● Facilitating professional reasoning.
Supportive (Restorative)	The maintenance of harmonious working relationships with a focus on morale and job satisfaction. ● Dealing with job-related stress ● Sustaining worker morale ● Developing of a sense of professional self-worth.
Administrative (Normative)	The promotion and maintenance of good standards of work, including ethical practice, accountability measures and adhering to policies of administration. ● Clarification of roles and responsibilities ● Work load management ● Review and assessment of work ● Addressing organisation and practice issues.

Adapted from Northern Sydney and Central Coast Area Health Service, Social Work Supervision and Consultation Guideline, November 2009, p. 4.

Clinical supervision and operational management

Supervision includes educational, supportive and administrative functions. This may be delivered via a combination of clinical supervision and/or management processes.

How and by whom supervision is provided is influenced by the context in which the clinician is working and by service delivery needs. In NSW Health there is a diversity of clinical teams and organisational structures which will impact the manner in which supervision is provided to an individual. It is acknowledged that there is no single method which would adequately cover the diverse nature of these structures.

For example a clinician may:

1 receive both clinical supervision and be operationally managed by the same individual of the same discipline.

2 report to an operational manager/unit head of the same discipline and have a different clinical supervisor from the same discipline within the same unit.

3 report to a team leader from a different discipline for operational management and receive clinical supervision from another person of the same discipline from outside their team.

These are only three of many possible examples of supervisory relationships which can exist in NSW Health.

Good supervision and staff management are essential to support clinicians. Whilst they can be seen as separate processes they are in fact complementary and must coexist. Some of the literature supports the separation of clinical supervision activities from management activities due to the inherent power imbalances which exist within a line management relationship (Smith 1996, 2005). This could potentially impact on a supervisory relationship if not managed appropriately. Some suggest the two processes should be conducted independently or by separate individuals (Country SA 2009; WACHS 2008). It is acknowledged however, in many settings within NSW Health these roles are often performed by the same individual (SWAHS 2010). In this situation roles can be made clear through the process of contracting (page 17). The table below outlines some of the differences between clinical supervision and operational management.

Clinical Supervision	Operational Management
• Driven by the clinical development needs of the clinician • Targeted to promoting patient safety • Facilitates skills acquisition • Provides a forum for discussion of ethical practice issues • Promotes reflective practice	• Promotion of positive working relationships between individuals and teams • Managing for performance • Management of human resource issues such as staff development, mandatory training and annual leave • Allocating and monitoring workload or caseload proactively in collaboration with the clinician.

Adapted from Allied Health Clinical Support Framework, Country SA, SA Health, May 2009, p 36.

Facilitating clinical supervision

The components that contribute to effective clinical supervision include:

- understanding the roles and responsibilities of key individuals and organisations
- setting the expectations of the supervisory relationship
- using supervision contracts
- maintaining supervision documentation
- evaluating the effectiveness of supervision
- setting learning goals
- facilitating reflective practice
- providing a culturally safe and respectful environment.

Who provides clinical supervision?

Clinical supervision can be provided by senior clinicians, line managers, service managers, team leaders and external supervisors. Deciding who provides clinical supervision depends on the context, including the clinical setting, award requirements and the availability and skill mix of staff. It is acknowledged senior clinical specialists may find it difficult to access suitably experienced clinical supervisors.

In some cases, supervision may be sought from external professionals or organisations, often on a fee-for-service basis, as well as or instead of supervision provided from within the organisation. The availability of external clinical supervision will depend on local policy and the context in which the clinician is working (eg, rural or in isolation).

Roles and responsibilities

Clinical staff and senior management have a responsibility to ensure high quality clinical supervision is occurring within Local Health Districts which is provided in a culturally safe and respectful manner. The following individuals play a key role in contributing to the governance of clinical supervision.

Director of Allied Health: is responsible for the professional management of allied health services in Local Health Districts and is the responsible officer for issues pertaining to the employment, progression and registration of allied health staff. The Director of Allied Health is responsible for ensuring that supervision processes are in place across Local Health Districts.

Discipline-specific head: when appointed within a facility or Local Health District, the discipline-specific head may have both operational and professional oversight of professionals from that discipline in the facility/Local Health District. The discipline-specific head ensures that policies, procedures and appropriate systems of governance to promote supervision are in place and that supervision processes are evaluated and improved.

Team leader/Service manager: may be responsible for operationally managing one or more allied health clinicians from the same or different discipline backgrounds. Where the team leader or service manager is unable to provide clinical supervision to the allied health clinician due to the absence of required skill mix, discussions should occur to arrange appropriate support from outside of the team or service.

Senior allied health clinicians: are required to provide supervision and support to less experienced staff. Senior allied health clinicians are responsible for providing supervision which may be conducted one to one, in groups or remotely.

Allied health professional educator: some services may have allied health professional educators who are able to provide support and coordinate networks with clinicians responsible for supervision, clinical education and training.
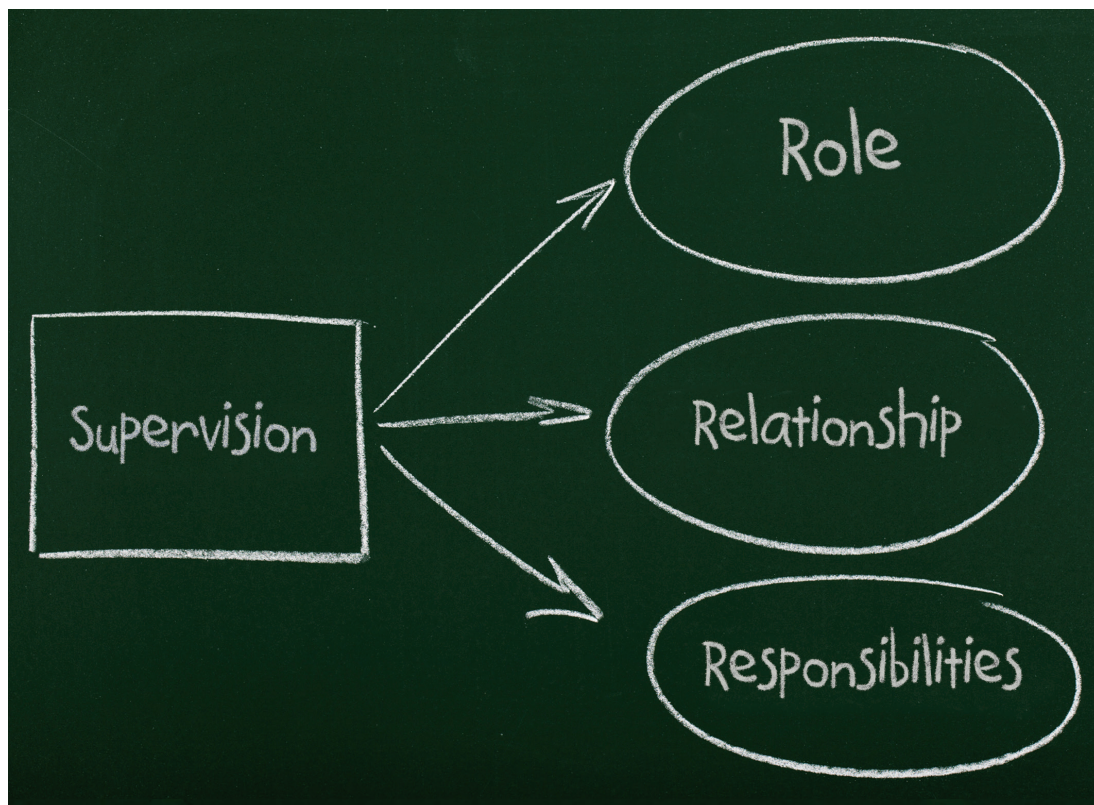
Governance for clinical supervision

In addition to structures and support within Local Health Districts, there are a number of organisations involved in the governance of clinical supervision for allied health professionals and in developing training and resources to support supervision.

Professional boards: In July 2010, national registration for some allied health professions replaced state registration. Pharmacists, physiotherapists, podiatrists, psychologists and (from July 2012) occupational therapists and medical radiation scientists must comply with the requirements of their respective boards to achieve general registration. For some professions minimum continuing professional development activities/hours are required which may also include a specified number of hours devoted to clinical supervision. It should be noted however professional board requirements for supervision to maintain registration are not uniform across disciplines and individuals must check their individual registration requirements. If an allied health professional is unfit to practice, the relevant registration board must be notified. This is an infrequent process that is guided by local policies and involves the Director/Manager of Workforce, the Director of Allied Health and the District Chief Executive.

Non-registered health professionals: In NSW, non-registered health practitioners are required to comply with the NSW Government Code of Conduct for Non-Registered Health Professionals.

Professional associations: Discipline-specific professional associations may also have guidelines regarding specific supervision requirements and competency standards for their profession.

NSW Health: There are a number of NSW Health policies which are applicable to the professional practice of allied health professionals. For more information go to www.health.nsw.gov.au.

Methods of supervision

Supervision may occur in the following ways:

- On a day-to-day basis
- Structured one-to-one sessions
- In a group environment
- Peer-to-peer

> In addition to local policy, the frequency and duration of supervision should be guided by requirements of registration bodies and/or professional associations.

Day-to-day supervision

Is conducted where the clinician has access to their supervisor in "real time" to facilitate the delivery of patient care. Also known as "informal" supervision, it can occur face to face, over the phone or even remotely via email. In addition, the supervisor may provide physical or "hands on" assistance if required to build clinician confidence and to support the delivery of safe patient care.

One-to-one structured supervision

Is conducted regularly, as determined by local supervision policies or professional practice requirements. The supervision session time should be protected and prioritised by both the supervisee and the supervisor. Supervision should be conducted in an appropriate environment that facilitates patient care/case discussion, reflective practice, and the setting and monitoring of learning goals and objectives. In the case of rural or sole/isolated clinicians, one-to-one supervision may be done by telephone, videoconference or online.

Group supervision

The purpose of group supervision is to provide a forum for facilitated open discussion and learning from each other's experiences. This may include clinical case discussions, topics of interest, interprofessional collaboration and team work. Group supervision is lead by a clinical supervisor and can be conducted face to face or via the use of telehealth and online technology, particularly for rural, remote or sole practising clinicians.

Peer supervision

Is usually conducted between two or more experienced allied health professionals as a method of consultation, problem solving, reflective practice and clinical decision making. It provides a forum for sharing of knowledge and experience and is used to complement more formal avenues of supervision (for group and peer supervision see page 24).

For supervision to be effective, it is recommended as a minimum that day-to-day supervision is provided in conjunction with one-to-one structured supervision sessions at a frequency relative to the supervised professional's experience in the clinical area and years of practice.

Adapted from South Eastern Sydney and Illawarra Area Health Service, Department of Nutrition and Dietetics, Central Hospital Network, Clinical Supervision Program and Procedures, 2011, p.5.

Supervision in rural and remote settings

It is recognised that clinicians working in rural and remote settings experience unique challenges in both obtaining and providing supervision. Some of the common issues experienced by rural clinicians include but are not limited to:

- The line manager is often also the supervisor hence it is challenging moving between both roles
- Line management of clinicians is often outside of the specific discipline
- Working in small department/teams and/or hospitals means there are fewer staff available to provide supervision and or/supervisors can experience burnout
- Working in isolation/as a sole clinician means there is reliance on the individual to be proactive in seeking support remotely
- Rural clinicians often work across a range of inpatient, outpatient and community settings which adds an additional level of complexity to the delivery of services and educational needs of the clinician.

Obtaining the required level of support may require "thinking outside the box" to harness resources and to obtain support from networks of peers or even staff located within other Local Health Districts.

Tips for rural and remote clinicians

- Encourage staff members to seek support and help from other clinicians:
  - ▶ within the local area
  - ▶ outside the local area (including metropolitan centres)
  - ▶ from professional bodies
- Network with other clinicians both within and outside of the Local Health District both in rural and metropolitan areas via email, phone and social media
- Join or create a peer support network to share experiences and learn from each other (for tips on group/peer supervision go to page 24)

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RURAL SCENARIO

A sole practising podiatrist is line managed by their local allied health operational manager who is an occupational therapist. The nearest senior/experienced podiatrist is 200 km away. Whilst the operational manager provides day to day support, the podiatrist requires clinical supervision external to the service to facilitate their ongoing development and provide a forum for reflective discussion. The podiatrist discusses the need for external clinical supervision with the operational manager. Arrangements are made for telephone supervision to occur with another podiatrist who works in a metropolitan hospital. In addition, the podiatrist contacts other podiatrists in rural areas and sets up a rural peer support network which meets via teleconference once a month to discuss ongoing issues, complex cases and complete reflective practice.

Setting expectations

When establishing a relationship between a supervisee and supervisor, it is important to ensure from the very beginning that clear boundaries are set and both parties have clear expectations of the process.

> **The quality of the relationship between the supervisor and the supervisee is the most important factor of effective supervision.**
>
> **(Kilminster & Jolly 2000)**

Staff who are new to a department or clinical area need a comprehensive orientation. For more information on what should be covered in orientation, refer to page 63.

An effective way to set expectations from the very beginning is to discuss:

- perceived strengths of both parties
- current concerns or fears
- areas the supervisee would like to develop
- how the supervisee learns best (recognition of different learning styles)
- what level of support the supervisee currently feels they require
- what the supervisee expects from the supervisory relationship
- what has worked/not worked for the supervisee in supervision in the past.

The supervisor should also discuss with the supervisee:

- the frequency of one-to-one supervision sessions
- expectations of the supervisee regarding the supervisory relationship
- availability and willingness to be contacted as assistance is required
- the best way to access advice on a day-to-day basis.

This will assist both parties to manage potential issues or concerns as they arise because a point of reference regarding expectations has been established.

It is important that the supervisor does not perceive or project to others that supervision is a burden. Supervision is an opportunity to support the development of staff and ensure the delivery of high quality patient care. Supervisors should ensure the staff they are supervising feel genuinely supported and that their role as a supervisor is taken seriously.

Supervision contracts

An effective way to ensure that expectations of the supervisory relationship are clear at the outset is by completing a supervision contract. Whilst this is separate to the managing for performance process, the two are both linked to productivity and performance of the individual clinician.

A supervision contract is a document which outlines the parameters of the relationship including the responsibilities of each individual. It is signed by both parties and forms the basis of the supervisory relationship. A copy should be kept by the supervisor, supervisee and the line manager (if applicable) in a central file as a reference document.

Items covered in a supervision contract may include:

- requirements as outlined in the local supervision policy
- goals of supervision
- frequency and time allocation for supervision
- parameters of confidentiality within the supervisory relationship
- evaluation of the supervision process
- the process if either party feels the supervisory relationship is not working or that the contract has been broken.

Examples of supervision contracts are given in Appendix A (page 72) and Appendix B (page 73).

Confidentiality

Confidentiality is vital to supervision. Agreeing on the parameters of confidentiality protects personal and sensitive information and upholds professional integrity (Country SA 2009).

Confidentiality should be discussed as part of establishing the supervision contract.

This includes:

- mutually agreed reporting procedures if duty of care issues are raised by the supervisee
- mutually agreed reporting procedures if the supervisor has duty of care concerns pertaining to the supervisee
- agreement in relation to what feedback can be given to the line manager
- ensuring discussions are held in private and documentation is kept in a secure place.

It is important for staff to be aware that there are limits to a confidentiality agreement in the case of misconduct or following adverse patient care events.

Documenting supervision sessions

The agreed actions and outcomes of the discussions which occur during one-to-one supervision sessions should be documented on a supervision record form. This provides additional guidance to the supervised clinician regarding areas on which they need to focus, and records the agreement of both parties regarding actions they are committed to taking.

Notes can be taken by either the supervisor or supervisee during the session. The documented record should ideally be signed by both parties, who should each keep a copy.

Supervision records are legal documents and in the context of misconduct or legal proceedings arising out of adverse events may be used as evidence. Supervision notes must be objective and accurately maintained according to NSW Health standards and stored for a period of time in line with NSW Government State Record Requirements www.records.nsw.gov.au.

Examples of a supervision session sheet and log sheet can be found in Appendix C (page 75) and Appendix D (page 76).

Evaluating supervision

It is important to have systems in place to evaluate the quality and effectiveness of supervision. Evaluation of the supervisory relationship is a joint responsibility of the supervisor and the supervisee. Perspectives of both the supervisee and the supervisor should be included.

There are several ways to evaluate supervision, such as:

- review of the supervision contract
- regular review or reflective discussion throughout the supervisory relationship
- through a debriefing after a critical incident, misunderstanding or breakdown in communication
- using an evaluation form or other formal evaluation process
- through informal discussion.

A useful feedback form which can be completed to evaluate the effectiveness of a specific one to one supervisory relationship can be found in Appendix E (page 77).

Clinical supervision activities

Developing learning goals

Good supervision underpins individual professional development and can positively influence the career path of allied health professionals.

Every clinician should have an individual learning plan with specific learning objectives detailing what it is they are working towards. This provides a framework for learning and a reference to reflect upon in subsequent supervision sessions and (if appropriate) during formal reviews (page 62).

When developing learning goals, the supervisor needs to ensure that appropriate educational objectives reflect the activities and clinical context of the supervisee.

Learning goals should be documented, discussed with the line manager (where applicable) and retained in the supervision record. They should be regularly reviewed and updated in line with the acquisition of skills and knowledge as the clinician develops.

Learning goals should be SMART: ie, they should be Specific, Measurable, Achievable, Realistic and Timely (Doran 1981). An example of a SMART goal template can be found in Appendix F (page 78).

Specific	Goal must be well defined, clear and unambiguous.
	● What do you want to accomplish?
	● Why?
	● Who will be involved?
	● Where will it occur?
Measurable	Define a criterion for measuring progress toward the goal.
	● How much?
	● How many?
	● How will you know when you have reached your goal?
Achievable	Goal must be achievable.
	● How will your goal be achieved?
	● What are some of the constraints you may face when achieving this goal?
Realistic	Goal needs to be relevant.
	● How does the goal fit with your immediate and long term plan?
	● How is it consistent with other goals you have?
Timely	Goal should be grounded within a timeframe.
	● What can you do in 6 months from now?
	● What can you do in 6 weeks from now?
	● What can you do today?

Examples of smart goals

Time and workload management

Within four weeks I will implement three strategies to improve skills in workload management. These strategies will be:

- making a list each morning of tasks that need to be attended to and identifying the priority of each task
- ensuring that half an hour each afternoon is scheduled in my diary to finalise notes and complete statistics
- checking emails twice a day only.

Presentation skills

Within eight weeks I will develop and deliver a presentation to my team members on a complex case within my current clinical area. I will achieve this by:

- identifying a relevant case
- exploring different models of case presentation via the literature and by seeking advice from other senior clinicians
- writing the presentation and linking practice to theory
- practising the presentation initially with my supervisor to get feedback and develop confidence
- delivering the presentation at the next team meeting or in-service.

Clinical skills

Within three months I will be able to autonomously manipulate the energy content of infant feeds for inpatients requiring extra calories by:

- accessing and reviewing all available protocols and guidelines in relation to manipulation of formula for paediatric patients
- discussing with my supervisor any questions or uncertainty about the process
- shadowing a senior dietitian in the paediatric unit in the first four weeks
- presenting four case studies to supervisor/senior dietitian which demonstrate accurate manipulation of the energy content of feeds
- getting a senior dietitian to check orders for one month to ensure 100% accuracy of orders.

Reflective practice

One of the most important skills allied health professionals can develop is the ability to critically reflect on their own practice. This includes identifying their strengths and weaknesses, determining actions required to improve their skills and developing clinical reasoning skills to ensure the delivery of safe patient care.

Reflective practice is an effective process to develop self-awareness and facilitate changes in professional behaviour. Reflection can occur before, during or after an event (Sandars 2009). When reflection occurs in supervision, it can be in relation to reflecting on day to day clinical practice, triggered by a challenging clinical encounter or in anticipation of having to manage a complex situation. It is imperative that reflective practice is conducted in a supportive environment to allow individuals to freely share information that promotes learning. Examples of how reflective practice is conducted include:

During structured supervision sessions the supervisee provides the supervisor with an overview of an issue or incident and the supervisor uses questioning to encourage reflection on its meaning (see example below).

Reflective journal/record keeping is a self-directed activity, where the clinician is guided by a template of key questions to record their experiences, work through the issues and reflect on their learning. They can then use this as a tool for discussion with their supervisor or to keep as a record of continuing professional development.

There are many models of reflective practice that can be used in supervision. One such model is Gibbs' model of reflection.

Model of reflective practice

Gibbs (1988).

The reflective cycle

- **Description** — What happened?
- **Feelings** — What were you thinking and feeling?
- **Evaluation** — What was good and bad about the experience?
- **Analysis** — What sense can you make of the situation?
- **Conclusion** — What else could you have done?
- **Action plan** — If it arose again what would you do?
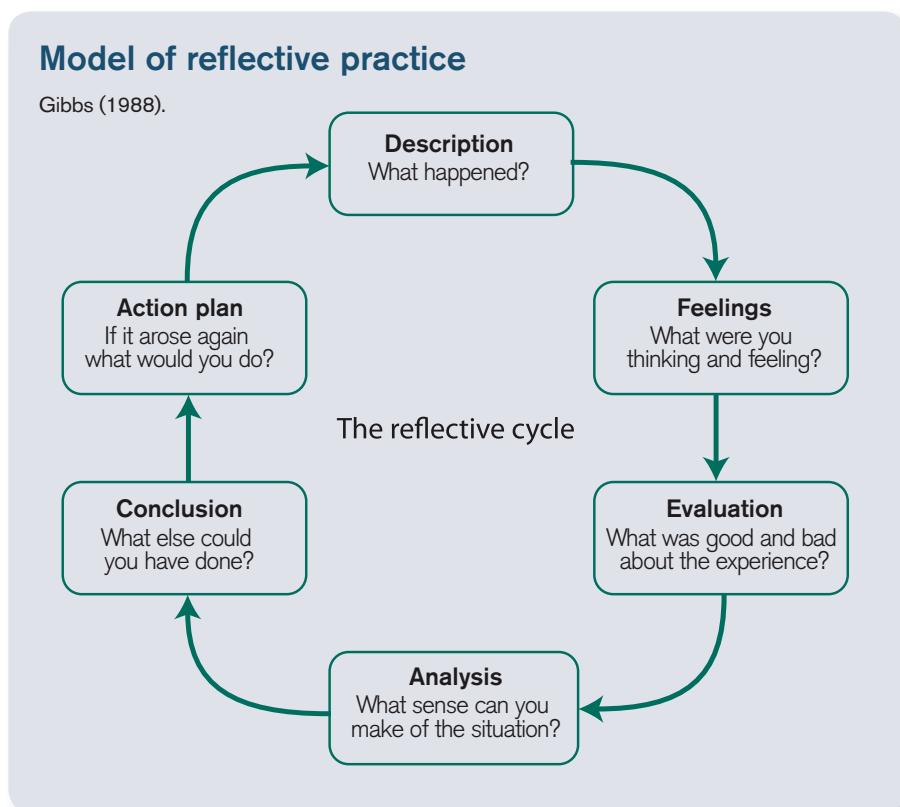
Gibbs' model of reflection — a practice example

Description

Describe as a matter of fact what happened during your critical incident or chosen episode for reflection

I was treating a patient with vascular dementia on the ward. I went to get him for therapy but he refused, instead insisting on going to the toilet. I asked him to wait until I got a nurse because he required a minimum of two assist to get out of bed. He then became agitated and attempted to get out of bed. When I asked him to wait until the nurse arrived to help, he became very aggressive. There were no other people in the room. The patient was leaning toward me and talking in a threatening manner, making personal derogatory remarks. He attempted to get out of bed again and fell. I then pressed the buzzer to call assistance. When the nurse arrived, we helped the patient back into bed and called the registrar to check him over. At that time I was asked to leave the room by the registrar and nurse.

Feelings

What were you thinking and feeling at the time?

I was very concerned about the safety of the patient because he fell, about my safety because of the level of aggression displayed towards me as well as my inability to manage the situation. When it was happening I was thinking that I needed to terminate the session as quickly as possible and get help but I felt stuck and I panicked. I was telling myself that I needed to stay in control, but I felt the situation was out of control.

Evaluation

List the points or tell the story about what was good and what was bad about the experience

I am surprised I was able stay in the room and not burst into tears. I attempted to settle the patient down to the point where I could leave him to get help but I was unsuccessful. Distracting him seemed to work only for a short while. I should have pressed the buzzer earlier. I felt guilty that he fell and embarrassed that I did not think quickly enough on my feet to press the buzzer.

> **'Critical reflection requires an ability to conceptualise and analyse, together with willingness to examine the assumptions underpinning ones practice, in order to improve it.'**
> **(Napier 2006, p.7)**

Analysis

What sense can you make out of the situation? What does it mean?

I think the patient was taken by surprise when I came in. Even though I explained why I was there, he had just woken up and was disoriented. I should have checked with the nurse about his presentation and paid attention to these signs as potential triggers to his aggression. I later found out that the patient was suffering from delirium.

Afterwards I was very upset and tearful. I did not want anyone to know that I was upset so I did not say anything. I felt however that this experience made me doubt my practice and the incident affected my self confidence.

Conclusion

What else could you have done? What should you perhaps not have done?

Because I was in a rush that day I did not have time to plan the session properly or consult with key team members. Despite warnings that this patient can become agitated, I thought I could quickly treat him because I previously had good rapport with him. In hindsight, I think I should have taken the time to organise to see him with a colleague or on another day, but I was overwhelmed with the amount of work I had to get through and patients I had to see.

Action plan

If it arose again, what would you do differently? How will you adapt your practice in light of this new understanding?

I think that it is not worth "just trying to get though the day". It's important to plan intervention or treatment with patients who are more challenging. I realise now that I contributed toward the incident by not planning my intervention properly and not calling for assistance sooner. I also recognise that it was important for me to talk the incident through with my supervisor and reflect on all aspects of the situation in order to learn from it.

An example of a reflective practice template can be found in Appendix G .

Group supervision

- Many of the principles of one-to-one supervision are just as applicable in the group supervision context.
- Group supervision is led by an appointed supervisor. However, individuals can gain from the reflection, feedback, sharing and input from colleagues as well as the supervisor.
- Like all supervisors, group supervisors require specific knowledge and skills, in particular about managing group processes.
- Do some planning prior to establishing a supervision group, to ensure it is the most appropriate/feasible form of supervision and will meet the needs of the allied health clinicians requiring supervision.
- Carefully consider the composition of the group and selection of staff to be supervised. Important considerations include how many supervisees are in the group, as well as the skills, experience and individual attributes of the supervisees.
- Developing a clear supervision contract that is agreed to and signed by all is essential. This includes the frequency of meetings, participants, model of supervision, role of the supervisor, expectations of the supervisee, review and evaluation processes and confidentiality.
- It is important that there is clarity about how feedback will be given to individuals in the group and that a culture of learning and self-reflection is fostered amongst participants.
- Group dynamics do occur in group supervision and need to be managed.
- Managing time equitably and ensuring that the needs of each participant are met should be constantly monitored.

Peer supervision

- Peer supervision is much more a self-directed activity and involves two or more allied health staff meeting to supervise each other's work.
- It requires a strong motivation and commitment from all participants to drive the process. The responsibility for the group, its wellbeing and ensuring it meets its purpose is shared by all participants.
- Whilst peer supervision is often considered a less "formal" process, it still requires a clear purpose and structure. Contracts and/or agreements are important and should address goals, expectations of participants, how the process will work and any "ground rules".
- Groups may include staff that have had supervision training, but members share the responsibility for convening and facilitating sessions with members often taking turns in being the supervisor and supervisee.
- It often works well with staff of similar training and experience that share values but hold a range of experiences.

- It can be a valuable adjunct to formal supervision. It is also a consideration when addressing the needs of experienced clinicians or clinicians in rural settings
- It can involve a mix of case discussions, theoretical discussions, role plays or case based learning.
- It is important that there is clarity about how feedback will be given to individuals in the group and that a culture of learning and self-reflection is fostered among participants.
- Like all supervision, peer supervision requires regular review to ensure it is meeting participants' needs.
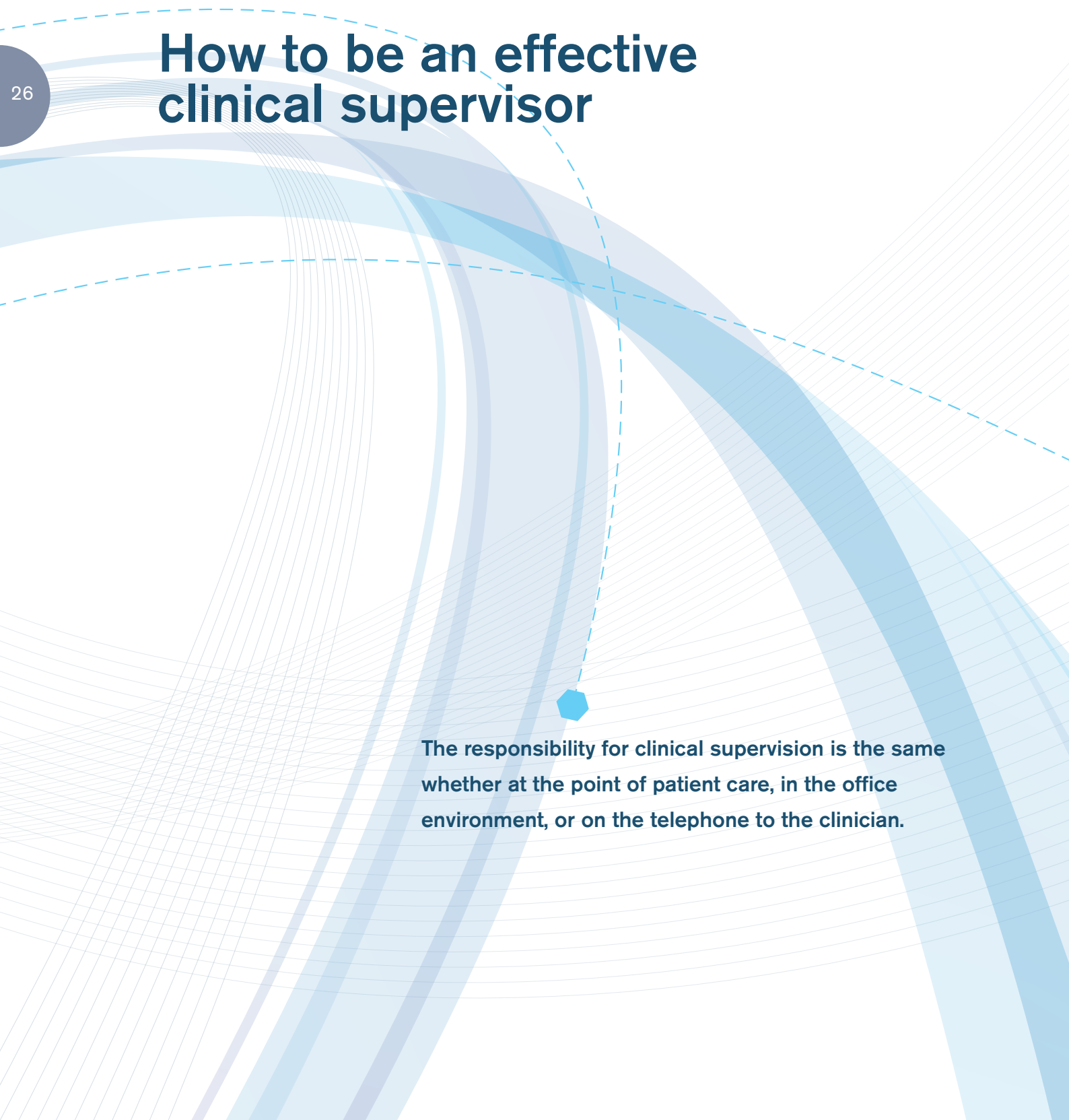
Checklist for effective supervision:

- ☑ Keep the clinician safe and well by actively monitoring his/her level of stress and ability to cope
- ☑ Acknowledge the current skills and experience of the clinician
- ☑ Address the individual needs of the clinician, including learning style
- ☑ Acknowledge the clinician as a person
- ☑ Provide positive reinforcement when new skills and knowledge are acquired to reinforce learning
- ☑ Develop a supervision contract which clearly defines the roles and responsibilities of the supervisory relationship
- ☑ Maintain confidentiality within the limits of the supervision contract
- ☑ Ensure feedback is provided in a positive way and addresses areas of further development clearly and unambiguously
- ☑ Acknowledge and manage factors that may influence the relationship (eg, seniority, gender, culture)
- ☑ Provide a supportive, professional but friendly environment, free from any intimidation
- ☑ Conduct supervision in the context of building a clinical team in which all members are accorded professional respect.

Part two

How to be an effective clinical supervisor

The responsibility for clinical supervision is the same whether at the point of patient care, in the office environment, or on the telephone to the clinician.

What makes an effective clinical supervisor?

Many allied health supervisors report that they simply do not have the time to actively supervise staff in the way that they would like. This is a real problem with no easy solutions. However, even small changes in how supervisors organise their clinical duties can make big differences to the effectiveness of supervision.

Time spent actively supervising allied health professionals is rewarded in two ways. The first is that active supervision improves staff performance, which saves time and enhances patient care. The second is that supervisors who increase their involvement with staff tend to report higher levels of job satisfaction, as playing a leading role in the development of allied health professionals is personally rewarding. It builds better team interactions and contributes to self-esteem for all involved.

In order to provide high quality supervision, there are a number of skills which supervisors should ensure they actively focus on developing.

Supervisory skills

Being available: This is the big one! Clinicians appreciate receiving advice from their supervisor when they encounter clinical situations beyond their current ability.

Being aware: Supervisors should know what level of supervision is necessary for safe practice. They anticipate red flags and should be ready to respond if necessary.

Being organised: To make the most of the limited time available, it is important for a supervisor to be organised. This includes prioritising time for structured supervision sessions.

Personal skills

Empathy: Do you remember what it was like to be a more junior clinician? A good supervisor uses insight and understanding to support supervisees.

Respect: Showing respect for clinicians and others promotes positive working relationships. This should occur regardless of individual differences and levels of experience.

Clarity of expectations: A common problem for clinicians is uncertainty about what their supervisor thinks or wants. Clear expectations and honest feedback from supervisors is highly valued.

Confidentiality: Staff are more open and honest about errors or lack of capability if they can discuss these matters in confidence with their supervisor.

A motivating and positive attitude: Most people respond best to encouragement, and feedback is more effective if framed in constructive terms.

Ability to reflect on practice: A supervisor who is able to reflect on their own practice provides a valuable role model for supervisees.

Willingness to allow staff members to grow, be independent and make some mistakes without fear of blame: While the aim of supervision is to minimise risk to patients and build confident and competent professionals, everyone makes mistakes. All supervisors were junior clinicians once and should acknowledge that some of the most important lessons learned were from making mistakes and putting plans into action to prevent them from happening again.

Clinical skills: The modelling of good clinical skills is one of the most effective ways that supervisors help their staff. The clinical skills of supervisors should be up-to-date and evidence-based.

Teaching skills: In order to be an effective teacher it is important to invest in your own professional development to enhance teaching skills. For more information on teaching refer to Section Three.

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The A-rated clinical supervisor

- Available
- Approachable
- Able (as both clinician and teacher)
- Active (finds the gaps)
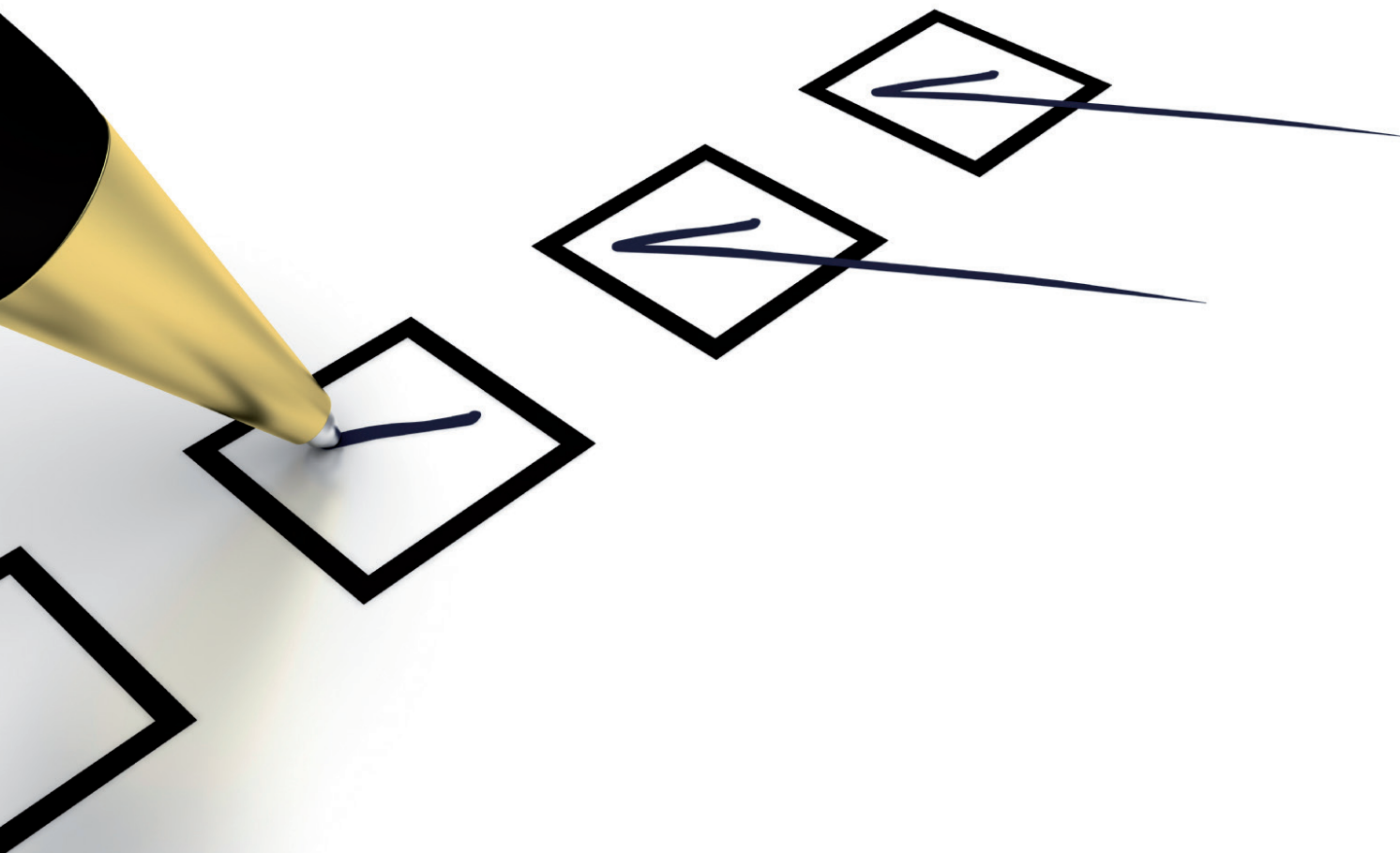
Barriers to effective supervision

It is important to identify the components which do not contribute to high quality supervision and address these where possible.

Being absent or unavailable: Limited or no supervision and/or a lack of access to a supervisor is ineffective and creates anxiety amongst staff. It also has a direct impact on the delivery of high quality and safe patient care.

Being rigid: Setting rules without giving reasons or giving instructions without an explanation does not contribute toward a positive supervisory relationship. This is not to say that supervisors have to explain everything all the time but there has to be time for explanations.

Intolerance and irritability: This leads staff to avoidance (eg, hiding errors and gaps in their capability).

Telling instead of coaching: This can lead to staff feeling unsupported and unable to develop their skills within the context of their learning styles and education needs.

Having a negative attitude or "blaming": Publicly criticising the staff member's performance or seeking to humiliate the staff member leads to adverse relationships.

Not managing staff in difficulty: There are many reasons for suboptimal performance, including poor orientation or poor supervision. Not supporting staff in difficulty has a direct impact on the quality of patient care delivery.

Getting to know your supervisee

Patient safety comes first

← Where is your supervisee
on the learning curve? →

Have you checked their skills?

Patient safety is a core
responsibility of all clinical
staff that cannot be delegated.
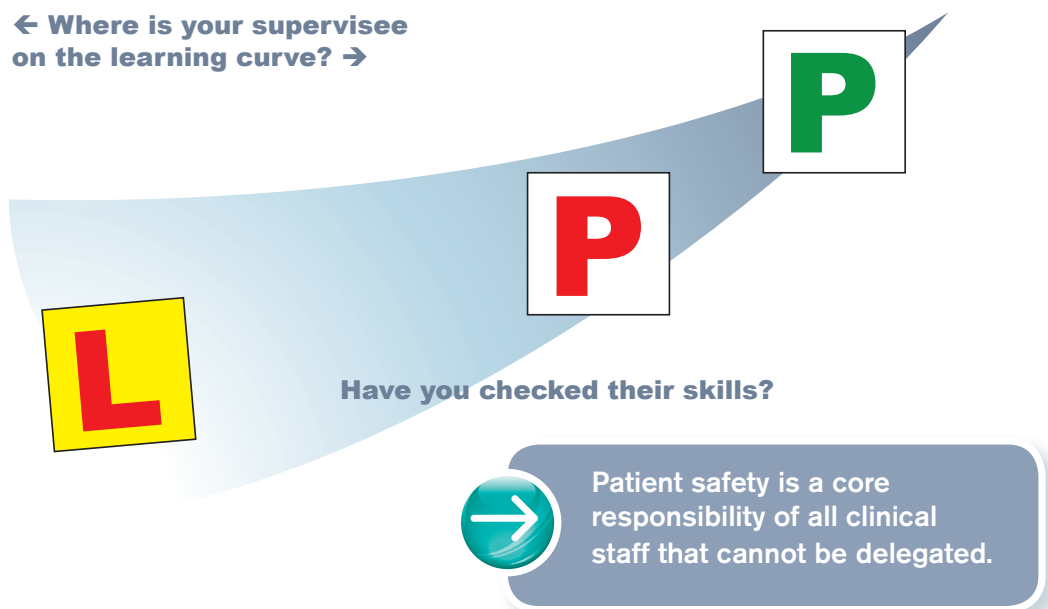
The clinical care and safety of the patient is the responsibility of all health care professionals. It is important when establishing the supervisory relationship to ascertain the clinical skills of the supervised clinician, whether they are a new graduate or moving into a new clinical speciality.

For example, a physiotherapist may move from orthopaedics, where they are a confident practitioner, to respiratory medicine, where they have not worked. While they may be confident in biomechanical assessment and treatment approaches, they may require further development of specific skills under supervision such as cardiopulmonary interventions before completing these tasks independently or being rostered after hours and on call.

Situations as described above are common place in the NSW Health system. To ensure patient safety it is critical that the supervisor:

- discusses the intervention plan for the patient with the supervisee to facilitate clinical reasoning and decision making to ensure safe patient care
- routinely oversees patient care as required to ensure that allied health professionals are acting competently
- is vigilant to detect triggers for a need for further involvement (to prevent or correct management errors by staff or to escalate care)
- is accessible when assistance is sought or ensures there is someone else to go to when the supervisor is absent.

It is far better for supervisors to be actively engaged in supervision that prevents errors and maintains standards than to attempt to manage problems after the event.

Knowing your supervisee's competence level

In the learning cycle described by Peyton (1998), staff move through four stages in the acquisition of particular competencies, from unconsciously incompetent to unconsciously competent.

Unconsciously incompetent:
The staff member does not know what they do not know.

Danger at this stage:
An inadequately supervised staff member may unwittingly do harm.

Response:
Supervise closely (hands-on), and address the knowledge gaps of the staff member.

Consciously incompetent:
The staff member knows that they do not know.

Danger at this stage:
Staff members may avoid situations that test their incompetence.

Response:
Supervise closely (hands-on), and encourage the staff member to overcome their inexperience.

Unconsciously competent:
The staff member can perform the task competently with practised ease.

Response:
The staff member no longer needs supervision in this task. Get them involved in teaching it to others.

Consciously competent:
The staff member can, with thought, perform the task competently.

Danger at this stage:
Atypical circumstances or pressure may cause the staff member to fail despite previous success.

Response:
Supervise with hands off, provide praise, recognition, opportunities to practise.

Active supervision

Active supervision occurs when the supervisor is sufficiently engaged and vigilant to support staff when they need help, whether or not a request for help is made. Active supervision acknowledges that some staff, or all staff in some situations, are "unconsciously incompetent" — that is, they do not know what they do not know, and will not always recognise situations that are beyond their current abilities where patient safety may be at risk. Active supervision requires the supervisor to continually seek clues or evidence that direct patient care or more support from the supervisor is required.

A key concept: hands-on, hands-off

An effective supervisor knows when to give staff direction and when to give them freedom of action. To move the staff member from consciously incompetent to consciously competent, the supervisor must actively calibrate the level of support provided.

The concept of "hands-on, hands-off" supervision was originally developed for the training of junior doctors, but can also apply to allied health professionals.

Iedema et al. (2008) put forward a model of clinical supervision that recognises the need for support and independence. It was found that supervisees value supervisory support of two kinds:

"Hands-on" supervision — when the supervisor is directly involved in monitoring or helping the supervised clinician as he/she performs tasks.

"Hands-off" supervision — when the supervisor trusts the supervised clinician to act independently, leaving space for the supervisee to deploy emerging skills and test growing clinical abilities. However, "hands-off" supervision is not the absence of supervision!

In general, staff need more hands-on supervision when tasks are new and increasing amounts of hands-off supervision as they progress and increase their skills, confidence and competence. Staff members also value an intermediate zone that allows them to shift back and forth between monitored (hands-on) and independent (hands-off) practice.

"Hands-on" supervision

- Guidance on interventions that require further skills development
- Specific skills training sessions
- Seeing patients with supervisor
- Discussing mistakes
- Opportunities to discuss patient management.

"Hands-off" supervision

- Identifying crucial supervision moments
- Allowing room to develop independence
- Feeling trusted
- Providing opportunities for de-briefing and discussion.

From a supervisor's point of view, both hands-on and hands-off supervision are active processes, requiring the exercise of judgment.

To work out how much hands-on and hands-off supervision your staff member needs, it may be helpful to ask yourself: *How far along the trajectory of development is the staff member? When is it time to intervene?*

Case study: clinical supervision

A social work team leader allocates a new referral to a clinician on the team. The referral is to assess a serious child-at-risk situation. The team leader is busy and has been paged to an urgent meeting. Two more experienced team members have called in sick and there is no one else to receive the referral.

What next?

Path one	Path two
The team leader gives the referral to the clinician and asks that they attend to it as a matter of urgency. She lets the clinician know that she will be unavailable and in meetings for the rest of the afternoon.	The team leader asks the clinician if she has capacity to take on a new referral, highlighting the complexity of the case and that it involves the assessment of a child at risk. The clinician explains that she has not previously had to report a case to child protective services.
The clinician assesses the situation and due to serious concerns makes a referral to child protective services. Due to the nature of the concerns they attend the hospital and assume care of the child and restrict parental visiting.	The team leader goes through the key elements of a risk assessment and ensures that the clinician feels able to proceed. She explains she will be in meetings but the staff member could page her after the assessment.
There is angry confrontation between the parents, the social worker and child protective services. It is witnessed by other parents and security is required to attend. Three days later, nursing staff complain to the clinician's supervisor as they were not involved in the case management planning. The supervisor had not spoken to the clinician since the incident and now needs to address the complaint.	During a break from meetings the team leader, conscious that she has not heard from the clinician, makes contact by phone. The social worker explains that she has been caught up and that child protective services are coming to the hospital. The team leader advises speaking with the nursing unit manager and multidisciplinary team to develop a management plan. The team decide the meeting with the family will occur away from the bedside and public ward area with security on standby. Despite the challenges of the situation the assumption of care occurs without incident. The team leader follows up by making a time to discuss the case with the clinician.

Path one exemplifies limited supervision, with the team leader abdicating responsibility and assuming that her supervisee has a level of knowledge, experience and autonomy that she has not yet achieved. It results in tensions within the multidisciplinary team and a lack of support for the clinician.

Path two outlines the supervisors ability to identify competence of the supervisee and builds on her knowledge base through logical questioning. The supervisor is active and follows up with the clinician to offer guidance, while still allowing the clinician to manage the situation. Support and an opportunity for learning after the case is also provided.

Giving feedback

Feedback is an essential component of supervision and must be clear so that the staff member is aware of their strengths and weaknesses and how they can improve (Kilminster & Jolly 2000). To give effective feedback:

- **Be timely:** Give feedback as close as possible to the event. However, pick a good moment for feedback (not when you or the staff member is exhausted, distracted or upset). Feedback on performance should be a frequent feature of your relationship with your supervisee.

- **Be specific:** Vague or generalised praise or criticism is difficult to act upon. Be specific and the staff member will know what to do. Adopt a straightforward manner, be clear and give examples where possible.

- **Be constructive:** Focus on the positive. Avoid dampening positive feedback by qualifying it with a negative statement ("You did well in choosing the correct intervention for Mrs Smith, but ..."). For constructive criticism, talk in terms of what can be improved, rather than what is wrong. Ask the supervisee for a self assessment of their performance. Try to provide feedback in the form of solutions and advice. At the same time, if the staff member makes an error, feedback needs to clear.

- **Be in an appropriate setting:** Positive feedback can be effective when given in the presence of peers or patients. Negative feedback (constructive criticism) should be given in a private and undisturbed setting.

- **Use attentive listening:** Supervisees should be given the chance to comment on the fairness of feedback and to provide explanations for their performance. A feedback session should be a dialogue between two people.

(Cohen 2005; Lake & Ryan 2006)

Consequences of a lack of clear feedback to underperforming staff

- Clinical care is not as good as it could be
- Anxieties and inadequacies are not addressed
- When weaknesses are exposed later in their career, the staff member has difficulty accepting criticism because of previous "good reports"
- Others are blamed when the staff member is unsuccessful
- Learning is inhibited, career progression is delayed
- Staff are not given the opportunity to develop to their full potential.

(Cohen 2005)

Providing feedback – an example from psychology

During a supervision session, a supervisee presents the case of a 10-year-old girl suffering from anxiety. He gives a formulation that focuses on the behavioural symptoms without taking account of the family history or the parenting style.

The supervisor affirms the positive aspects of the assessment and then explores the supervisees' understanding of the causes of anxiety in children, thus attempting to elicit the areas to be further explored. When the supervisee fails to mention the impact of family history and parenting style on anxiety in children, the supervisor raises this and gives a specific example of a situation where this information changed the clinical management plan. The supervisee is then given an opportunity to reflect on the feedback, discuss its relevance in this particular situation and how they will proceed.

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Supervisee engagement in supervision

While it is the responsibility of the supervisor to remain active in overseeing clinical care, as per the supervision contract, supervisees must be encouraged to engage and commit to the supervisory process. Supervision is one of the most important relationships of an allied health professional's career. This can be facilitated by actively encouraging the clinician to seek assistance when required and identify appropriate learning opportunities.

→ Effective supervision requires commitment, support and governance from management and organisations.

What makes an allied health professional feel valued?

- Being supported, especially when confronted with clinically challenging situations or while working out of hours, in isolation or outside the acute hospital environment including home and community visits
- Being given responsibility for patient care
- Good teamwork
- Receiving feedback
- Having a supportive learning environment
- Being stimulated to learn
- Having a supervisor take a personal interest in their work and professional development.

(Peyton 1998)

The A-rated teachable supervisee

- Attitude (not arrogant, anxious or overawed)
- Aptitude (has baseline of clinical skills, communication skills and knowledge)
- Attuned (focused on learning and not bored or perfunctory)
- Awareness (has good insight into abilities and is able to accept feedback and modify behaviour)

Tips to foster engagement of the supervisee

- Do the groundwork when establishing a new supervisory relationship. Developing mutually agreed expectations of supervision builds a solid foundation and helps address any future issues.
- Ensure you demonstrate to the supervisee that you view supervision as priority — make sure that supervision time is not hijacked by other competing demands.
- Regularly seek feedback from the supervisee about the quality of the relationship and the content of supervision.
- Be prepared to tailor supervision to meet the specific and changing needs of the supervisee.
- Address disengagement as a matter of priority.
- Develop an understanding of the supervisee's (and your own) learning styles and use this information to strengthen the learning and make supervision more meaningful.
- Review the logistics around supervision such as timing, venue and frequency, and ensure they continue to be suitable and are not impacting on attendance.
- Think of supervision as building on strengths rather than working on deficits.
- Be mindful that supervision can be anxiety-provoking for some staff, and ensure expectations are realistic and achievable.
- Regularly find opportunities to give positive feedback when the supervisee successfully uses the learning from supervision in their practice. This not only reinforces the value of supervision and increases the supervisee's clinical confidence, it also ensures that patients receive quality care.

Responsibilities of the supervisee

Whilst the supervisor has important responsibilities to engage, facilitate learning and provide support, equally the supervisee has an important role to play in getting the most out of supervision.
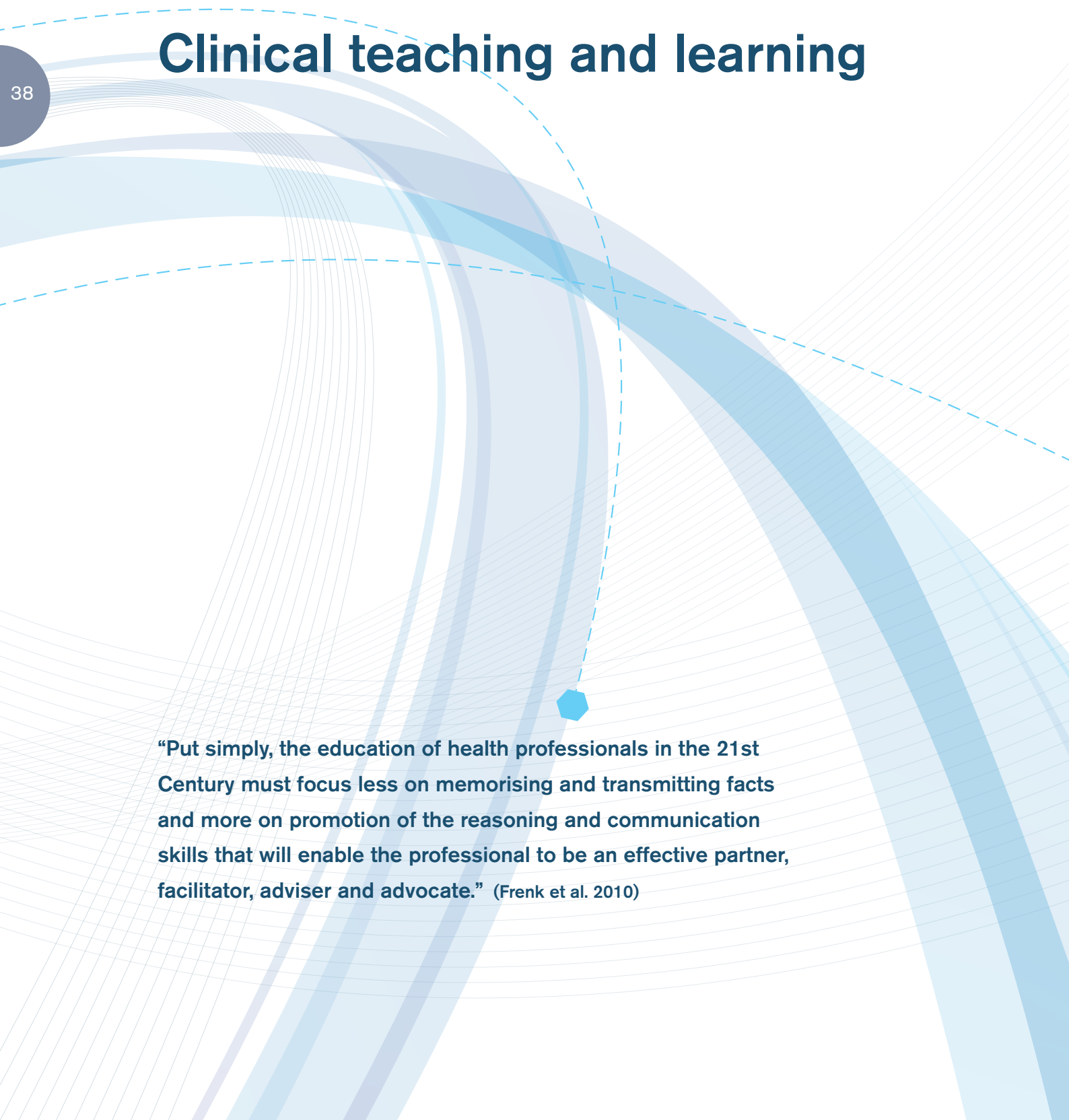
Supervisees should:

- take responsibility for self-directed, lifelong learning including a commitment to ongoing professional development
- actively participate in the supervision process
- openly express needs and expectations related to supervision. Ensure these form the basis of the supervision contract
- make the best use of supervision by coming prepared. This includes having an agenda of points to be discussed so time can be used effectively
- make an effort to create and protect time for supervision. Try to keep scheduled supervision appointments, be on time and try and avoid interruptions
- be prepared to openly identify and discuss practice issues which are challenging and the skills that need developing
- work at developing trust in the supervisory relationship so that issues can be discussed honestly and freely. This makes supervision more meaningful and relevant
- contribute to reflective discussion about practice experiences and learnings
- be open to learning and improving clinical practice skills and incorporating this learning into ones work practice. Be prepared to be challenged in a supportive way
- be open to receiving support and feedback during supervision and take time to reflect and respond to this feedback
- take responsibility for seeking help when required, even if outside the regular supervision time. This ensures patient safety and wellbeing are always put first
- commit to regularly reviewing the supervision process and give honest feedback if it needs to be adapted to meet changing needs.

Part three
Clinical teaching and learning

"Put simply, the education of health professionals in the 21st Century must focus less on memorising and transmitting facts and more on promotion of the reasoning and communication skills that will enable the professional to be an effective partner, facilitator, adviser and advocate." (Frenk et al. 2010)

The supervisor's role in clinical teaching

As per the functions of supervision outlined in section one, supervision also encompasses education. The purpose of the educational component of supervision is to develop each individual in a manner that enhances their full potential, ensure patient safety, effective and ethical practice. This may be complemented by the provision of education in other teaching forums such as in-service education, grand rounds and case discussion.

Clinical teaching aims to:
- improve knowledge and skills
- integrate theory into practice
- develop self awareness
- facilitate reflection on practice
- enhance clinical reasoning.

In addition to clinical skills, the supervisor should also teach the non-clinical skills needed to manage workload, interprofessional practice, team dynamics and the demands of the rapidly changing health care environment.

It is particularly important in the case of new graduate allied health professionals to recognise the stress experienced following the transition from the university education system, which is highly structured, to the workplace environment which requires the ability to work under pressure in a resource-constrained environment (Smith & Pilling 2008).

Some of the main challenges reported by new graduate allied health professionals are:
- managing a full caseload (including both complex and straightforward patients)
- having full responsibility for patients
- being confident in decision making and exercising authority
- managing time effectively
- completing paperwork.

(Smith & Pilling 2008; Tryssenaar & Perkins 2001)

Teaching in a clinical setting should therefore include assisting new clinicians to develop non-clinical skills to cope with workplace demands, teaching specific clinical skills and providing knowledge through formal education.

Promoting a culture of life-long learning

Supervision provides an ideal forum to promote a culture of lifelong learning. Lifelong learning refers to the continuous building of skills and knowledge through experiences encountered over the course of a lifetime. It encompasses not only structured learning through education but also learning through personal experience. Lifelong learning is linked to the pursuit of personal or professional knowledge and is voluntary and self-directed.

Linked to the concept of life-long professional learning, discipline specific professional associations and professional registration boards have guidelines regarding specific education requirements for their profession. This includes meeting continuing professional development (CPD) requirements and maintaining CPD portfolios. However, self-directed and lifelong learning is an attitudinal approach which should be modelled by all senior allied health professionals over the course of their career.

Facilitating the learning process

There are several approaches to learning that can occur within the context of supervision. Most people learn by a combination of deductive (learning through structure) and inductive (learning by experience) approaches. When facilitating learning, it is important to consider principles of adult learning, different learning styles and a mix of modalities.

Principles of adult learning

- Adult learners need to be respected, valued and acknowledged for their past experience and have an opportunity to apply this experience to their current learning
- Adults learn best in environments that reduce possible threats to self-concept and self-esteem and provide support for change and development
- Adult learners are highly motivated to learn in areas relevant to their current needs, often generated by real life tasks and problems
- Adult learners need feedback to develop
- Adult learners have a tendency towards self directed learning and learn best when they can set their own pace
- Adults learn more effectively through experiential techniques (eg, discussion and problem solving).

(Brundage & MacKeracher 1980; Brookfield1998)

Identifying different learning styles

Many models exist which describe different learning styles (Kolb 1999 and Honey & Mumford 2000). Learning styles can be determined through administering learning style questionnaires (eg, Myers-Briggs Type Indicator in Myers et al. 1998) or discussing with the supervisee how they learn best (eg, preferred learning style, environment and methods).

A learning style model

Concrete experience
Having an experience

Activists

Reflectors

continuum

Active experimentation
Putting their theory into practice

Processing *continuum*

Reflective observation
Reflecting on experience

Perception

Pragmatists

Theorists

Abstract conceptualisation
Drawing their own conclusions
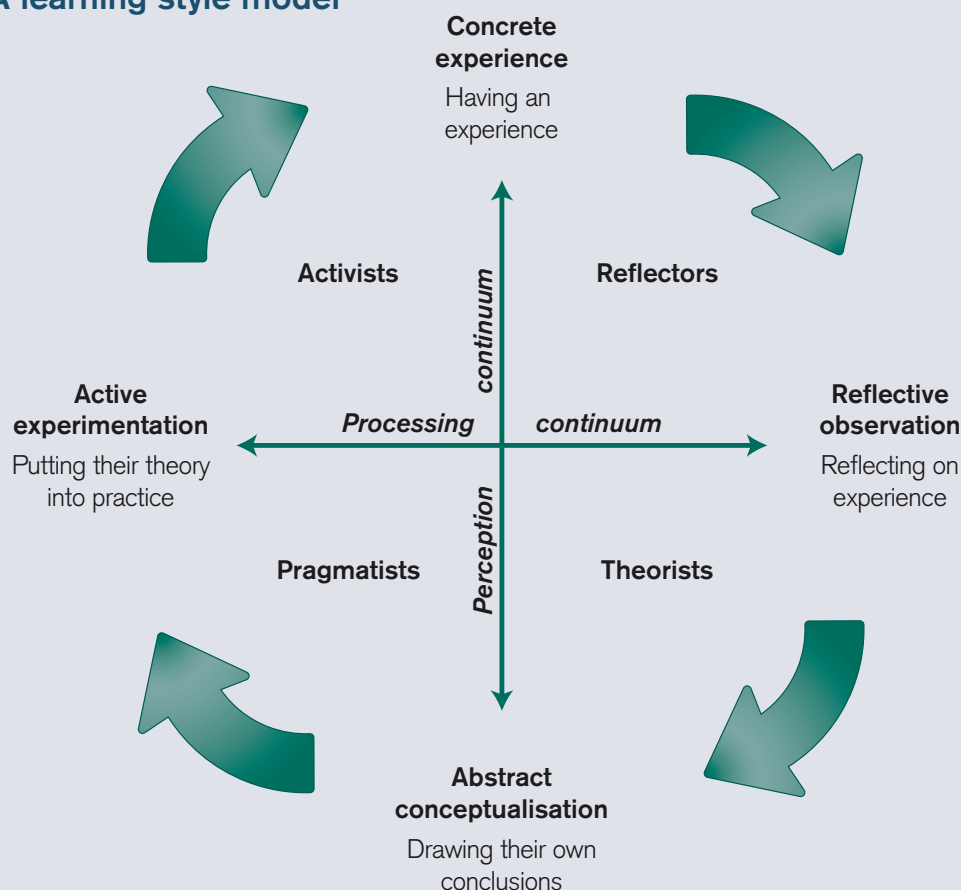
Reflector: Prefers to learn from activities that allow them to watch, think, and review (time to think things over) what has happened. Likes to use journals and brainstorming. Lectures are helpful if they provide expert explanations and analysis.

Theorist: Prefers to think problems through in a step-by-step manner. Likes lectures, analogies, systems, case studies, models and readings. Talking with experts is normally not helpful.

Pragmatist: Prefers to apply new learnings to actual practice to see if they work. Likes laboratories, field work, and observations. Likes feedback, coaching, and obvious links between the task-on-hand and a problem.

Activist: Prefers the challenges of new experiences, involvement with others, assimilations and role-playing.

Source: Honey P, Mumford A (2000). The learning styles helper's guide.
http://www.nwlink.com/~donclark/hrd/styles/honey_mumford.html

What makes effective clinical teaching?

Collaboration and active involvement. Adults like to have input into their learning.

Relevance to the clinical duties currently required of the staff member, or to their future career plans.

Ascertain what the staff member is interested in and then direct your teaching to this motivation. For example: for a junior occupational therapist (OT) currently working in general rehabilitation, principles of upper limb assessment and rehabilitation may be reviewed in more detail if they have a specific interest in neurological rehabilitation. There may be opportunities to develop skills and confidence by encouraging the staff member to take on more complex neurological patients as part of their clinical duties while the supervisor provides ongoing coaching and support.

Appropriateness to the level of the staff member.

Teaching by guided questioning. Asking and encouraging thinking.

Didactic teaching (lectures) is most effective when you know the knowledge base of your audience (ask first). A failure of some didactic teaching is that time is spent teaching staff members things they already know.

The advantage of guided questioning is that it reveals what staff members do know and invites them to extend their knowledge. But don't turn questioning into a grilling. Make sure staff members are provided with space to think about their responses and if they require more time to process what is being taught, offer to continue the discussion later once they have had a chance to reflect.

Setting clear learning goals with the staff member so expectations are clear. Document SMART learning goals: Specific; Measurable; Attainable; Realistic and Timely.

Giving feedback so that staff members know how they are going.

Seeking feedback so that you know how effective teaching has been.

Simply telling people what you expect them to learn will focus their attention in a clinical encounter.

Feedback given and received lets everyone know whether the intended outcomes are being achieved.

Adult learning is a collaborative process.

Ten top tips for the teaching supervisor

1 **Every little bit helps:** Seize the teaching moment. Even if you don't have the whole package worked out, it's still worthwhile sharing what you can, as best you can. Don't have time to run through a process or procedure in full? Draw the staff member's attention to one key aspect of the task. No time for a complete debrief immediately after a difficult case? Ask a few key questions to check the staff member's understanding of what occurred and give quick feedback. Follow up later when there is time.

2 **Teach by guided questioning:** Ask questions to discover the state of the clinician's knowledge and understanding. Encourage independent thinking and problem-solving. Effective questioning uncovers misunderstandings and reinforces and extends existing knowledge. Questions keep staff engaged, "on their toes", listening and thinking.

3 **Invite staff to set the agenda:** Adult learners should be involved in decisions about the direction and content of learning. Your ultimate objective as a supervisor is to foster the staff member's ability for self-directed lifelong learning.

4 **Encourage questions:** Questions from staff should always be treated with respect. You may be shocked at what they did not know, but on closer inspection, may discover that others are just keeping quiet. The three most important words in teaching and learning are "I don't know".

5 **Focus the learner:** Start any teaching by setting up the importance of the session. Teaching is more effective if it is tailored to learners' interests, ambitions and current level of knowledge and ability. Answer the question: why should they pay attention to what you are about to teach them?

6 **Focus the learning:** Don't try to teach too much at once. Try not to repeat what is already known. Clinical situations are complex but limit the learning to the key aspects that form the learning edge of your audience's knowledge base. Procedures and processes can be broken down into steps, not all of which have to be covered at once.

7 **Encourage independent learning:** Don't try to teach everything – give enough information to set staff on track, then ask them to complete the task themselves. Set tasks that require staff to act on the information you have provided. Keep learning open-ended. Encourage staff to seek other educational opportunities and report back on their learning.

8 **Teach evidence-based practice:** Build a lifelong learning attitude in your staff. Even more important than knowing the current best answer to a clinical problem is having the skills to identify a clinical question, search the clinical literature, appraise the evidence and form an evidence-based plan.

9 **Check the understanding of staff:** Have staff actually understood what has been taught? Can they demonstrate clinical reasoning and put knowledge and skills into practice? If not, perhaps revisit specific topics or skill areas until staff feel confident and can show that they have learned.

10 **Evaluate your own practice as a teacher:** How well did your staff learn from the information you provided? Every time you teach you have a chance to learn how to do it better (and more easily) next time. Try different methods and compare staff outcomes. Seek feedback from your staff. Compare notes with your peers.

Identifying opportunities for clinical teaching

There are many situations which occur on a day to day basis in a clinical setting which can be turned into opportunities for clinical teaching. While it is beneficial to allocate specific time for teaching (when required), using opportunities as they become apparent can be beneficial to clinicians. Some of the forums where teaching can occur include:

- in the presence of patients
- during case discussion
- during handover
- over the phone
- interdisciplinary (ie, with other allied health disciplines)
- interprofessionally (ie, with medicine and nursing).

Teaching in the presence of patients

Clinical teaching at the point of care is the place where theoretical knowledge is made practical in the real world, with real patients.

Supervisors can use opportunities to teach in the presence of patients by identifying patients from their own case load who would provide a beneficial learning opportunity to clinicians, or work with a patient from the supervisee's caseload.

In preparing to teach in the presence of patients the following principles should be applied.

Ensuring patient comfort

- If possible, provide advance notice to the patient.
- Obtain consent in private wherever possible and before the teaching session.
- Ensure introductions are made.
- All procedures, discussions and communications should be explained and made understandable to the patient as the teaching occurs.
- Thank the patient and invite questions.

Note: Patient safety, comfort, privacy and confidentiality is paramount and should be monitored at all times.

Tips for teaching in the presence of patients

- Start small, and stay within your comfort zone as a teacher.
- Remember what is routine to you may be new to the clinician.
- Allocate sufficient time for point of care teaching.
- Involve the staff member. Negotiate the goals. Let them select the focus of teaching.
- Orient the staff member to your plans prior to the session, including clarifying their role and what you hope they will learn from the experience.
- Skills/procedures can be modelled first by the supervisor and then demonstrated by staff or staff may perform all or part of the interview, procedure or intervention.
- Teaching by guided questioning is generally better than just telling, because it allows you to determine the person's level of knowledge and understanding. Ask the staff member to report back to check understanding.
- If the staff member appears to be struggling or is off track, make a smooth transition to take over the clinical interaction.
- Don't criticise at the point of care, debrief elsewhere constructively.
- Afterwards seek feedback from the staff member. Reflect on the effectiveness of the session and prepare for next time.

Teaching during case discussion

Case discussion may occur during the formal one-to-one supervision session or periodically during day-to-day interactions and discussion regarding patient care.

Supervisors can use these discussions to provide additional information, or to impart skills and knowledge that explain the need for specific interventions. It is also an opportunity to encourage reflective practice.

Using guided questioning to find out why the clinician feels a particular problem exists or should be solved in a certain way further develops strong clinical reasoning skills and confidence in clinical practice.

Teaching by guided questioning

Teaching by guided questioning encourages independent thinking and problem solving. It allows the supervisee to test options, analyse risk and consider limitations and innovations.

Examples of guided questions:

- What approach are you taking in this situation and why?
- Can you explain the steps of the task/treatment/intervention and why they are completed in this way?
- What outcomes do you want and how can they be achieved?
- What is your action plan if this approach doesn't work?
- What values, attitudes, knowledge and/or skills are being challenged in this situation?
- How would you approach the situation next time?
  (Irwin 2008)

Teaching at handover

Well structured handover is an excellent learning experience that integrates communication, professionalism and clinical management. Staff members learn techniques of clinical description and case organisation when involved in the handover of a patient to others. Handover is also an important team-building exercise.

Clinical handover is important to effective clinical care. The practical operation of health services, including hospitals, means that patient care might be handed over from team to team in various situations including:

- following on-call and weekend shifts
- transfer of patients from one clinical setting to another
- discharge planning.

Supervisors should discuss principles of good clinical handover to build the skills of clinicians and facilitate the safe transfer of patients from team to team.

Clinical staff may experience challenges with handover, in particular if they are on the receiving end of information about patients they are required to look after on an after-hours or weekend shift. This creates a risk for the patient as it is not possible for the staff member to check information with the treating therapist or ask additional questions once the day shift has gone home.

The challenge of handover

- Being confident to speak up and be an active participant in the handover process. Staff must feel able to ask questions if they are unsure of details in someone's handover.
- Providing the most critical and relevant information in sufficient detail to ensure the issues are clear (just enough versus not too much). This is vital to continuity of care and safe clinical practice.
- Ensuring time is prioritised in the daily schedule for handover of patient information, with consideration of all the points where handover may occur, such as from shift to shift, ward to ward and inpatient to outpatient.
- Being punctual and consistently turning up on time to handover sessions.
- Being organised and planning for absences such as periods of leave.
- Ensuring effective and accurate documentation of patient issues occurs in handover notes, medical records and discharge summaries.
- Maintaining patient confidentiality and privacy while providing appropriate clinical handover, particularly if referring to agencies outside NSW Health. (Further information is available in the NSW Health Policy Directive PD2005_593: Privacy Manual (Version 2) 2005 - NSW Health).

THE ISBAR framework for communicating at handover

ISBAR is the NSW Health accepted methodology for clinical handover. The process of handover should occur as per the framework outlined below.

Further information is available in the NSW Health Policy Directive 2009_060: "Clinical Handover – Standard Key Principles" (2009) and NSW Health Caring Together "Implementation Toolkit – Standard Principles for Clinical Handover" (2009).

I	**Introduction** – Identify yourself, role, location and who you are talking to.	"I am (name and role), from (ward/facility) and I'm calling because (clear purpose)"
S	**Situation** – state the patient's diagnosis/reason for admission and the current problem.	"The situation is that I have a patient (age/gender), who is (diagnosis/deteriorating/stable). My concerns are (clear and succinct concerns). The current presenting symptoms are (clear, current and relevant symptoms and observations)."
B	**Background** – what is the clinical background or context?	By way of background (Give pertinent information which may include: Date of admission / presenting symptoms/ medication / previous recent vital signs / test results/status changes and any relevant medical and social history)
A	**Assessment** – What do you think the problem(s) is? (Don't forget to have a key issues list ready!)	"My assessment on the basis of the above is that the patient is….. they are at risk of ... and in need of ..."
R	**Recommendation** – What are you asking the person to do?	"My recommendation is that this patient needs (what test/action) by (who) within (timeframe)." Repeat to confirm what you have heard, eg, "I understand that I am to ... and you will …"

→ **Clinical handover is the effective transfer of professional responsibility and accountability for a patient, or group of patients, to another person.**
(NSW Department of Health 2009a)

Tips for teaching at handover

- Supervisors can select particular patients as the subject of teaching.

- Handover is an excellent opportunity for clinicians to take the lead in a teaching session. Ask the clinician to select a case to present in more detail regarding the patient's background, who they are being handed over to, why, and what is the essential handover information that the receiving clinician/team needs to know to meet the patient's care needs.

- Aim for one teaching point at each handover. A brief (not exhaustive) exploration of a key issue is of lasting value for the staff involved.

- All staff members should be familiar with the ISBAR framework for communications at handover, which is recommended for all clinicians in the NSW Health system (NSW Department of Health 2009b).

Failures in handover have been identified as a major preventable cause of patient harm. Allied health professionals need to be encouraged to value the task of handover and to see it as an essential and integral part of their daily work.

Example: handing over by phone with ISBAR

Transfer of a patient to an external facility for rehabilitation from one speech pathologist to another.

Introduction: Hello I am (name), speech pathologist calling from the acute stroke unit at the Royal Hospital. I am calling to hand over care of Mr Smith who is being transferred to the rehabilitation ward at your facility this afternoon. Will you be the person managing him in rehab?

Situation: Mr Smith is a 78 year old gentlemen who currently has moderate oropharyngeal dysphagia, and moderate dysarthria affecting intelligibility in conversational speech. His language is functional but mild aphasia is present. He is currently on a modified minced diet with nectar fluids, is taking medication orally and his chest is clear. He has right upper and lower limb weakness affecting his ability to self-care, including feeding himself. He requires the assistance of one person to mobilise with a transfer belt and assistance of one for self care.

Background: The patient presented at Emergency on 31 May 2011 with slurred speech and right upper limb weakness. The CT showed the presence of a left middle cerebral artery thrombolytic stroke. The patient has a history of high LDL cholesterol, IHD and diabetes. He is retired and was previously living independently at home with his wife who is fit and well. He has a supportive son who lives nearby.

Assessment: A swallowing assessment from speech pathology demonstrated a weak, delayed swallow and high aspiration risk. A subsequent modified barium swallow (MBS) was conducted, resulting in him being placed on a modified minced diet with nectar fluids due to delayed swallow with pooling in the pharyngeal valleculae leading to aspiration risk. He has also been receiving dysarthria therapy once a day directed at improving intelligibility while in the acute stroke unit. The family has been present during therapy sessions and are keen to participate in the treatment plan for the patient to assist return to independent function. Based on his recent MBS, the patient continues to require a modified diet, but is keen to progress to normal fluids as soon as possible.

Recommendation: Based on his risk of aspiration and ongoing speech difficulties, Mr Smith would benefit from therapy to improve oro-facial muscle tone, conversational speech intelligibility and a possible repeat MBS prior to progressing to thin fluids. It is recommended that Mr Smith undertake a period of inpatient rehabilitation to achieve his goals of enhanced swallowing function and improved speech quality. A follow up MBS may also be required.

Thank you for taking over care of this patient. I have completed a detailed discharge report which I will fax over to detail the treatment plan to date and recommendations. A separate MBS report will also be attached. Do you have all the information you need to take over care of this patient? Please don't hesitate to page/phone me if you require further information.

Teaching remotely

Many clinical consultations and episodes of supervision take place over the phone, via email or video conferencing. Despite the distance, the supervisor's advocacy for patient safety is no less than when present at the point of care. There is a tendency to abbreviate phone calls to a minimum of information exchange, but the phone can be used to put the supervisor "virtually there" with the clinician during clinical encounters. Because the supervisor cannot see or touch the patient, there is an increased focus on the clinician's communication skills.

Particularly in non-urgent contexts, the supervisor can work with the clinician to develop his/her phone communication technique:

- Practice the ISBAR communication framework (see page 49)
- Provide feedback to the clinician on the selection and presentation of clinical information
- Practice the "report-back" technique of confirming the content of a phone communication with the clinician (repeat the essence of what you have been told and repeat the decisions for action that have been made).

Fear of difficult conversations with supervisors can discourage supervisees from making a phone call at the time when it is most needed. Supervisors need to support staff members' use of the phone/teleconferencing and paging system and develop their skills in presenting information succinctly and accurately to elicit the support and advice required.

Other clinical teaching opportunities

Critical responses

When there is a critical incident, and there is no time for explanations, it is important to make time to review the event afterwards.

After-hours episodes

A lot of clinical activity occurs "after hours," which includes work conducted after business hours and on weekends. For some allied health staff, their experience is drawn from episodes of care provided "after hours" on an episodic or on-call basis.

Supervision and training needs after hours are important and require monitoring and support by senior clinicians. After-hours clinical situations can be a source of anxiety for clinicians, as the patients and their conditions may be unfamiliar.

The supervisor must be alert to this unfamiliarity and provide a supportive environment. Staff working after hours should have access to senior staff supervision as required. Providing support to reason through a clinical problem together can enhance patient safety and the person's ability to manage independently in future.

Teaching clinical skills

Skills training can begin with virtual experience (eg, texts, scripts, videos, online tutorials, simulations, role plays) but it has to be completed in the workplace with real patients. Supervisors need to be ready to teach a skill when the opportunity arises.

A four-step approach to teaching skills described by Walker and Peyton (1998) and adopted in Teaching on the Run (Lake & Ryan 2006), is:

1 **Demonstration:** Trainer demonstrates the skill at normal speed, without commentary.
2 **Deconstruction:** Trainer demonstrates the skill while describing the steps required.
3 **Comprehension:** Trainer demonstrates the skill while the staff member describes steps required.
4 **Performance:** The staff member demonstrates the skill and describes steps while being observed by the trainer.

Tips for teaching clinical skills

- **Don't forget fundamentals:** hygiene and infection control; patient communication, consent and introductions.
- **Demonstration:** make sure the learner can clearly see what you are doing. Demonstration by the supervisor can be combined with performance by the learner.
- **Integrate theory with practice:** that is, not only demonstrating skills but explaining the logic and the evidence behind the practice. This helps to develop clinical reasoning.
- **Don't teach everything at once:** particularly for the demonstration of more complex skills or procedures, not every step needs to be taught in every encounter. Begin by establishing what the staff member already knows. Review the unknown steps in more detail.
- **Provide opportunities to practice skills:** making time and space available for the staff member to be hands-on, breaking procedures into steps, providing direction and sharing care. Repetition is the key to skills training, with the focus of teaching building on competency.
- **Use collaborative problem solving:** give staff a clinical problem and work with them towards a solution.
- **Give feedback:** that is timely, specific, and constructive. Ensure feedback is given in an appropriate environment. Good givers of feedback also invite feedback from the staff member, with a view to improving their teaching technique.
- **Provide appropriate learning resources:** knowing what is available to help staff develop a deeper level of understanding.

Opportunities for teaching clinical skills

Profession	Example
Audiology	Conducting tests such as ABR (Auditory Brainstem Response) assessment, ENG (Electronystagmography), ECogG (Electrocochleography).
Diversional Therapy	Planning and implementing a leisure education program to address leisure related barriers.
Exercise Physiology	Completing advanced exercise assessment and prescription. Rapidly identifying changes to client's health status through observation and assessment.
Genetic Counselling	Interpreting a family history to assess risk of genetic disorder.
Nutrition and Dietetics	Developing a nutrition care plan for a patient requiring an enteral feed.
Medical Radiation Science	Managing complex radiological evaluations of patients with co-morbidities.
Music Therapy	Understanding the steps of common clinical procedures to incorporate music for relaxation/distraction.
Occupational Therapy	Assessing functional mobility in the community using a power chair. Prescribing pressure-relieving mattresses and cushions.
Orthoptics	Instructing in the practice of investigation and management of complex adult strabismus.
Orthotics	Preparing a custom-made orthosis for a complex paediatric client according to developmental parameters.
Play Therapy/Child Life Therapist	Preparing a child for clinical procedures such as an operation or intravenous cannula insertion.
Pharmacy	Preparing an individualised medication plan for a patient with complex co-morbidities.
Physiotherapy	Undertaking a gait assessment with a stroke patient.
Podiatry	Managing an ulcer/wound on a high risk foot. Conducting minor nail surgery with local anaesthetic.
Psychology	Undertaking a psychometric assessment.
Social Work	Undertaking a thorough psychosocial assessment and documenting it in the medical record.
Speech Pathology	Undertaking a modified barium swallow assessment. Undertaking a paediatric feeding evaluation.

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Teaching an audiology skill

A client is booked in to the audiology unit for an auditory brainstem response (ABR) assessment. The junior clinician is aware of the test but has never done it in practice. The senior clinician elicits from the junior clinician reasons why this test may have been chosen for the client rather than a standard audiological test battery. The set up of the test is explained and the junior clinician is guided through the process of preparing the client, including practical processes such as how to attach the electrodes. The test is run and the junior clinician is guided through the process of correctly identifying ABR responses on the trace and marking them. The senior audiologist and junior audiologist together explain the results to the client and prepare a report for the referral source.

Outcome: The junior audiologist has learned the clinical reasoning behind selecting an auditory brainstem response as an assessment, how to set up the test and how to interpret results.

Teaching a podiatry skill

The senior podiatrist and junior podiatrist are managing a wound on a patient with Type II diabetes.

Some of the components of managing a wound include wound debridement, choosing the correct dressing and using an aseptic dressing technique. The podiatrist discusses the type of wound on the patient's foot: location, shape, borders, exudate, infection and base. Following this discussion the senior podiatrist demonstrates an aseptic dressing technique.

The senior podiatrist then shows the junior podiatrist different types of dressing materials and asks the junior podiatrist to choose and discuss which dressing would best suit the wound. The junior podiatrist then takes over the procedure and debrides the wound and applies the correct dressing using an aseptic dressing technique.

Outcome: The junior podiatrist has learnt the correct procedure for wound debridement, choice of wound dressing and aseptic dressing technique.

Teaching non-clinical skills

Time management and setting priorities

One of the hardest skills to master is the effective prioritisation of clinical work to meet the needs of patients and service demands. This is a skill which takes time to develop and is often difficult even for the most experienced clinicians. An inability to effectively prioritise workload can leave clinicians feeling overwhelmed and overlooking essential tasks which need to be completed to facilitate the delivery of safe patient care.

In addition, being a productive member of a discipline specific or multidisciplinary team also requires completion of administrative tasks, projects and quality improvement activities on top of day-to-day clinical work.

In assisting the staff member to develop skills in time management and prioritisation, the supervisor can guide the person to implement some of the following strategies:

- quarantining specific sections of the day for direct patient contact activities and back of house activities
- managing unexpected interruptions and learning to say "no" or "at another time" when appropriate
- prioritising patients in order of urgency/risk
- creating "to do" and patient activity lists
- scheduling time during each day to complete documentation tasks
- allocating a specific time to make phone calls (eg, making phone calls in 15 minute blocks)
- setting time aside to respond to emails/complete statistical requirements once a day
- being flexible to reprioritise work on a daily or even hourly basis.

Developing skills in teaching and education

Skills in clinical education must be learned like everything else in clinical practice. Years of experience in clinical practice alone does not in itself make a great clinical teacher (Strohschein, Hagler & May 2002).

"Expertise in clinical practice does not imply expertise in clinical education"
(Strohschein, Hagler & May 2002, p. 162)

Clinical supervisors should be actively seeking to improve their knowledge and skills surrounding:

- principles of adult learning
- current evidence in clinical education
- delivering effective presentations
- benefits of blended learning
- providing constructive feedback
- facilitating reflective practice and clinical reasoning
- utilising broad based evidence to inform practice.

Skills and knowledge can be obtained through blended learning methods including:

- self-directed learning
- sharing of information and resources
- review of literature in a group format such as a journal club
- online learning packages
- participation in simulated learning environments
- attending face-to-face courses in clinical supervision and education.

Formal teaching

As a senior clinician, you may be required to give in-service training and presentations, and the one clear advantage is that your subject will probably match your expertise. Practice these tips to make your presentations effective:

- Consider your audience and shape your material to make it relevant to their current knowledge, clinical responsibilities and objectives. If in doubt, consider using questions at the start of your presentation to establish where to pitch your talk.

- The first five minutes are vital. Capture interest with a compelling start (why should the audience listen?) and explain what you intend to cover in your talk. If you have one key point above all, make it early.

- When using PowerPoint slides, don't dump all the information on the slide. White space, use of images and uncluttered slides with few words will ensure the audience pays attention to what you are saying.

- Don't read your presentation — most of all, don't read your PowerPoint slides. Talk to your audience and maintain eye contact.

- Stories, jokes and analogies are useful tools to make facts memorable.

- Respond to visual cues from the audience to change pace. Ask a question if you are not sure that the audience is with you.

- Vary your delivery and technique. Consider breaking the presentation with questions to or from the audience, or an activity to be carried out by the learners.

- Close your presentation strongly, with a summary of what you hope the audience will take away.

- Avoid overstuffing your presentation with material. It is better to be succinct and cover key points than trying to teach everything in one session.

- Obtain feedback in order to evaluate the effectiveness of your teaching and make improvements next time.

Beyond the in-service

Don't forget the broad spectrum of teaching methods available to you as a teacher as alternatives or adjuncts to providing in-services:

- simulations and role plays
- videos to demonstrate techniques or behaviours
- group discussions, case studies and problem-based learning
- computer-based education.

These subjects go beyond what can be covered in this book — so explore. Even the simplest departures from the standard in-service format will make the content of your education sessions more memorable.

Fostering interprofessional collaborative practice

This guide has provided some useful insights and guidance on issues relating to teaching and clinical supervision in the context of the public health system. Learning interprofessionally, when two or more professions learn with, from and about each other to improve collaboration and the quality of care (Freeth et al. 2005) can have many benefits to both patients and health professionals.

This marks a significant departure from the ways in which health care workers are traditionally educated and supervised: each discipline training or learning separately to work separately.

Interprofessional teaching and supervision can prepare health professionals to question taken-for-granted professional assumptions and explore different professional perspectives. It also prepares health professionals for team-based care or interprofessional collaborative practice (IPCP).

A growing amount of evidence has emerged outlining the benefits of IPCP which include:

- increased staff motivation, well-being and retention
- decrease in staff turnover
- increased patient and carer satisfaction
- increased patient safety
- increase in appropriate use of specialist clinical resources
- reductions in patient mortality and critical incidents, and
- increase in access to and coordination of health services.
  (WHO 2010)

Supervision and clinical education that facilitates greater awareness of the roles and responsibilities of others (doctors, nurses, other allied health staff and patients), and that motivates health professionals to engage and communicate with those from other professions, can better prepare health professionals for work in today's public health system.

Supervisors can consider fostering interprofessional collaborative practice by:
- facilitating an interdisciplinary group supervision session
- inviting relevant disciplines to participate in seminars, workshops, ward rounds, clinical reviews etc
- supporting interdisciplinary placement programs
- encouraging supervisees to enquire about the roles and responsibilities of other professional disciplines.
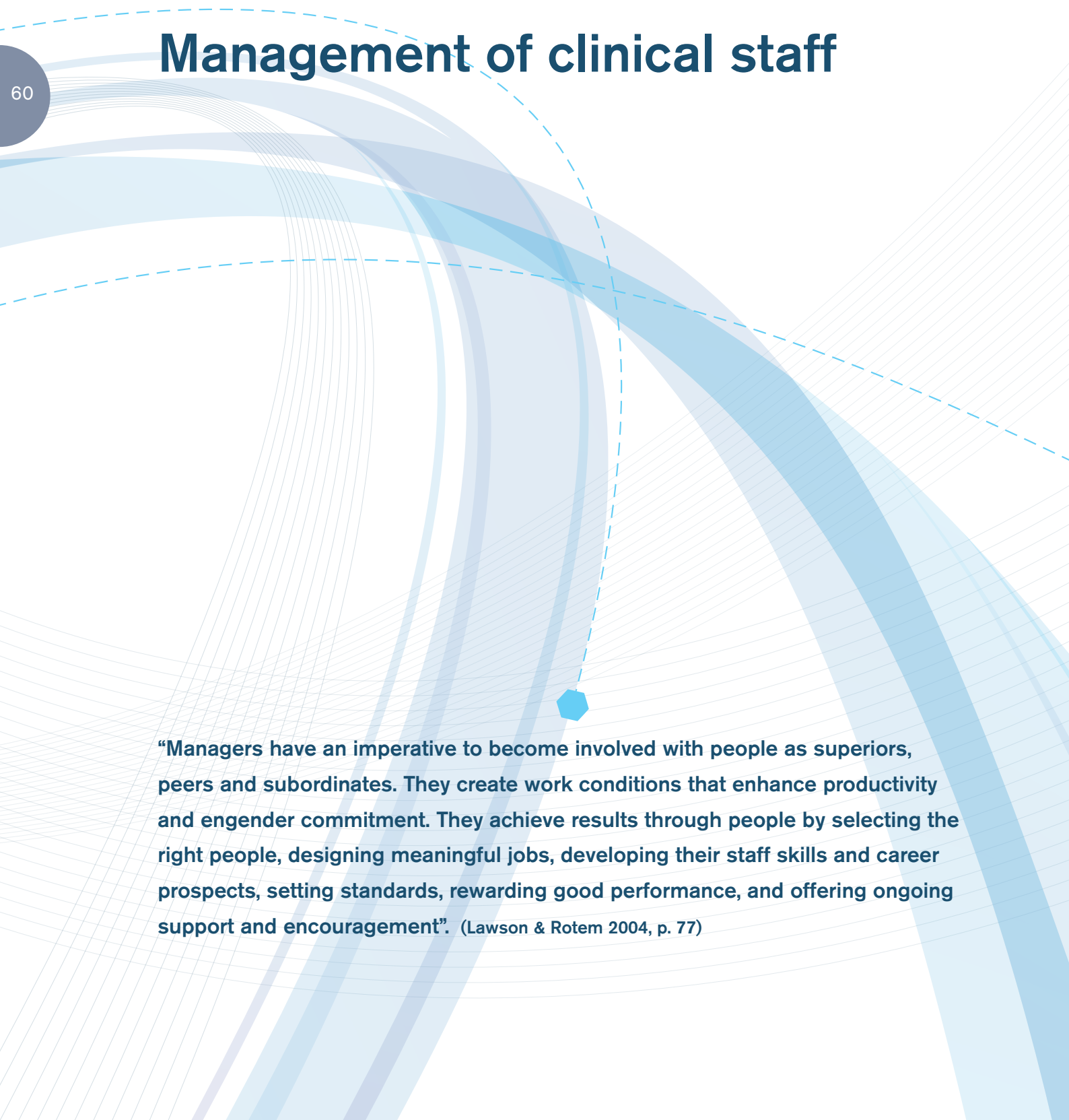
For more information on team-based care or interprofessional collaborative practice, visit the HETI website:
www.heti.nsw.gov.au

Part four
Management of clinical staff

"Managers have an imperative to become involved with people as superiors, peers and subordinates. They create work conditions that enhance productivity and engender commitment. They achieve results through people by selecting the right people, designing meaningful jobs, developing their staff skills and career prospects, setting standards, rewarding good performance, and offering ongoing support and encouragement". (Lawson & Rotem 2004, p. 77)

Managing clinical staff

As per the functions of clinical supervision outlined in section one, supervision also encompasses an administrative role. The purpose of administration is to promote and maintain good standards of work, including ethical practice, accountability measures and adhering to policies where they exist.

As discussed on page 9 of this handbook, in NSW Health there is a diversity of organisational structures and lines of reporting which need to be considered in the context of supervision. In some situations the clinical supervisor may also be the line manager and hence performs dual roles.

This can include the following tasks in relation to the supervisee:

- clarifying roles and responsibilities
- workload management
- review and assessment of work
- addressing organisation and clinical practice issues.

Key Tasks

There are some administrative tasks required to support a clinician which have an important role in clinical education and training. These activities may be performed by the line manager, supervisor or collaboratively between the two depending on local service arrangements.

Four key tasks include but are not limited to:

- managing for performance (to promote and encourage progress)
- orientation
- being or sourcing mentors, coaches and buddies
- managing clinicians in difficulty

There are many skills required to operationally manage clinical staff in NSW Health which are beyond the scope of this document. The following section aims to provide tips for supervisors on how to effectively carry out some of these tasks as well as explore some of the "common challenges" experienced by supervisors when attempting to manage and support a clinician in difficulty.

Managing for performance

In allied health managing for performance is generally undertaken by the operational line manager, which may include a unit head, team leader, head of department or service manager. This may be the clinical supervisor if they are also the line manager. However, if the clinical supervisor is not also the line manager they may also be involved in this process. This provides an opportunity for collaboration to occur for the benefit of the supervisee.

"Managing for performance is a process that commences with the recruitment and orientation of an individual and involves an on-going cycle of planning, coaching and reviewing individual, work, team and organisational performance within the context of the organisation's goals and strategies" (NSW Department of Health 2005a, p. 4).

It is important to note that managing for performance is not disciplinary action but is about ongoing two way feedback to promote development. It also involves a formal review often referred to as the annual performance review (NSW Health 2005a).

The process of clinical supervision links into the formal review as it is based on individual learning goals relating to clinical practice. These items can therefore be discussed in addition to the organisation/service requirements of the supervisee.

If supervision has been effective throughout the year, there should be no surprises at the formal review. The staff member should be well aware of the progress they have made and the opportunities for further improvement. This should be achieved through regular:

- feedback on performance
- review of learning goals
- one-to-one supervision sessions to discuss progress and opportunities for improvement
- use of reflective practice to develop increased self awareness.

Purposes of the formal review

- To provide staff members with feedback about their performance and facilitate their learning and development.
- To review evidence that staff members are progressing and achieving their learning objectives. A good review system should assure senior staff/management that allied health professionals are meeting certain standards of practice and competence before advancing to higher levels of responsibility.
- To set objectives for the following year and identify areas for professional development in line with service needs and the staff member's career aspirations.

For more information, please refer to the NSW Health Policy Directive, PD2005_180, Performance managing for a better practice approach for NSW Health 2005.

Orientation

Orientation is the key to effectively introducing a new staff member into the clinical area or facility and setting the supervisory relationship. Supervisors are often responsible for organising or participating in orientation for new staff members, even if they delegate parts of the orientation to other staff. Multidisciplinary orientation should be considered where possible as it immediately begins to meld the staff member into the clinical team.

Allied health professionals highly value a formal orientation. Not orienting a staff member sends some strong negative messages about the professionalism of the team they are joining. Lack of orientation is often a root cause of later problems that staff members may experience as they settle into their new role.

It is useful to have a checklist to ensure that orientation is comprehensive (see below). Wherever possible, include a face-to-face handover to a new staff member. A succinct (written or digital) orientation package is an excellent welcome gift. Such packages need regular updating.

Orientation provides the supervisor with the opportunity to review the staff member's current level of knowledge and experience and to develop a plan to meet their particular learning goals.

Benefits of a successful orientation extend to the whole clinical unit. With a multidisciplinary, interprofessional collaborative practice approach, teamwork and collaborative relationships are promoted and staff can be better supported. In addition, clinical care of patients will benefit from the use of standard procedures and protocols by all members of the team.

Checklist for orientation:

Orientation should include:

- ☑ the major focus and goals of the clinical team and the expectations of the clinician's role
- ☑ roles and responsibilities of the clinician and other members of the department
- ☑ three month review (or as per organisational requirements)
- ☑ expected daily tasks
- ☑ hints for successful interactions with other staff members (who is on the team – key team members and their roles)
- ☑ procedures for making referrals to internal and external service providers
- ☑ other administrative procedures, including documentation
- ☑ supervision needs
- ☑ learning objectives and skills training goals
- ☑ information about professional development opportunities
- ☑ general information about work practices, protocols and guidelines as they apply
- ☑ key principles of clinical handover (NSW Department of Health 2009a)
- ☑ the process of annual formal review.

Mentors, coaches and buddies

There are many ways which clinicians can obtain additional support to facilitate learning in the workplace. This may include obtaining a mentor, coach or buddy.

Mentoring has been described as a "developmental, caring, sharing and helping relationship where one person invites time, know-how and effort in enhancing another person's growth knowledge and skills" (Shea 1999, p. 3, cited in McCloughen, O'Brien & Jackson 2009).

Coaching is a solution-focussed approach used to assist people to retrieve and utilise their personal experiences, skills, intuition and expertise in order to find creative, individual solutions to work and personal life situations (Greene & Grant 2003).

Buddies are pairings of clinicians (usually one who is more experienced than the other) for similar purposes.

Informal mentoring, coaching and buddy relationships can naturally form in the clinical environment. They can also be formalised and deliberately fostered by supervisors as a support to clinical supervision. These relationships can also form the basis of a peer supervisory relationship. Some mentors and/or coaches have skills obtained through formal qualifications and training.

Coaching and mentoring can be used to complement an existing supervisory relationship or when the supervisor feels he or she does not have specific knowledge, skill and expertise in a particular area of the supervisee's interest (such as research) or a specific therapeutic modality. In this situation, the supervisor can source support from an appropriate colleague to act as a mentor or coach to the supervisee.

Providing a mentor, coach or buddy can be an effective way of:

- introducing a staff member to a new facility or a new clinical area
- supporting personal and professional growth and development
- helping a staff member in difficulty by giving an extra avenue of support
- building closer links within and between clinical teams.

It is important to note, mentors, coaches and buddies do not necessarily need to be from the same discipline as the staff member. Smith and Pilling (2007) demonstrated that the use of interdisciplinary peer support was valued by new graduate allied health professionals as part of an interprofessional education program.

Generally speaking, a formal mentor, coach or buddy to a staff member should not be the supervisor of that staff member, as the roles can conflict.

To be a good coach or mentor (Cohen 2005, Rose 1999)

As a supervisor or senior clinician, you may be approached to become a coach or mentor for another staff member. Here are some helpful tips to being a good coach or mentor.

Do

- Create a safe and supportive environment
- Establish a professional relationship built on mutual respect and trust
- Establish the focus of your coaching/ mentoring relationship, including an agreement for working together
- Collaboratively identify, agree upon and realise the mentoring or coaching goals
- Empathise, show patience and allow the staff member to express feelings
- Provide constructive feedback and clarify how the staff member would like feedback conveyed
- Ask appropriate and relevant questions that facilitate communication and clarification
- Identify and encourage strengths in the staff member
- Encourage the staff member to think reflectively and critically explore options together.

Don't

- Dominate or control the staff member (physically, verbally, psychologically)
- Allow interruptions to your coaching/ mentoring time or be distracted/ interrupted by "more important" issues
- Assume what you think the staff member wants to hear or learn
- Assume that staff members are used to being given constructive feedback
- Take over, show the staff member what to do, show off your knowledge or insist on the staff member doing things your way
- Create dependency on you
- Show irritation, impatience or annoyance
- Talk more than you listen
- Forget what you experienced when you were learning and developing
- Breach confidentiality.

Common challenges for supervisors

The goal of supervision is to bring out the best in every staff member. There are often challenging moments on the way to this goal. The challenges are unique to the individual and require solutions tailored to the circumstances. Many problems can be avoided by carefully orienting the clinician to their role and to the organisation, setting clear expectations and establishing a supervision contract. This will go a long way towards preventing any misunderstandings and alert the supervisor to issues that may need management.

It is recognised that most clinicians receive little or no formal training in managing staff issues and often acquire these skills through experience and/or modelling other senior staff behaviour. It is important that supervisors and managers invest in their own professional development and supervision to improve confidence in managing complex issues.

Many factors may affect a clinician's performance. Some of the more common issues (and potential responses) are listed below. The first response to any problem should involve a face-to-face discussion with the clinician. If the issues involved are sensitive, this should be conducted in a private location, free from interruptions and at a time when neither is distracted or overstressed. If the issues are serious or if attempts to resolve the issues are failing, it is appropriate to seek additional assistance. In particular, if supervision is provided separate to line management responsibilities, the line manager should be consulted.

Challenges and solutions

The clinician with communication problems: Does the clinician recognise that communication is a problem? If yes, remediation can be relatively straightforward (eg, writing courses, conversational practice, providing scripts or templates to model effective communication practices, providing a mentor or buddy, use of audiovisual equipment). If no, then the issue is more complex, because the solution has to begin with the clinician gaining insight into the problem. For example, members of the clinical team may report that the clinician is impolite and uncommunicative while the clinician considers that he/she is efficient and focused. Readjusting the clinician's perceptions involves developing his or her empathic ability and, if identified as a problem, should become the focus of supervision.

The clinician who is uninterested in the area of clinical work: It is best to identify this early and plan accordingly. In some instances, the clinician's lack of interest will be based on a misconception of the content of the work or on a failure to appreciate its relevance to their area of interest. In many cases, the supervisor can highlight aspects of the work that will be of interest to the clinician. In others, an appeal to the clinician's sense of responsibility to the team may motivate them.

The reluctant supervisee: Where the clinician has no interest or cannot see the benefit of supervision. The supervisee needs to be encouraged to see the importance of supervision as part of professional development and delivery of safe patient care. Ensure the supervisory relationship and process appropriately meets the needs of the supervisee.

The overconfident clinician: Overconfidence is potentially dangerous and it is important to provide a reality check at an early stage. This may occur by asking the clinician to provide advice on a hypothetical case and then through guided questioning, give a constructive critique of their management plan. Consider highlighting the potential consequences of overconfident practice in relation to a real patient. This should never be done in a way that will belittle or embarrass the clinician.

The perfectionist clinician: Some clinicians are so determined to do everything perfectly that they cannot meet realistic deadlines and are in danger of burning themselves out. It is important with these staff to develop an appropriate priority list and work on realistic time management skills.

Managing a clinician in difficulty

Any of the challenging situations described on the previous page, and others, may become a "clinician in difficulty" — somebody who is not progressing as they should and potentially placing themselves and others at risk.

A clinician in difficulty may be supported by both the supervisor and operational line manager. Clear processes defining the role of each person are required in the case where the line manager is not the clinical supervisor. Where there are specific clinical practice issues, a suitably qualified senior clinician from that discipline should be involved in the process.

It is important to recognise that, in the case of less experienced staff, being a junior allied health professional with limited experience can be challenging. Most problems can be resolved if they are appropriately identified and managed. The general approach to dealing with clinicians in difficulty rests on three principles:

1 Patient safety should always be the primary consideration

2 Clinicians in difficulty require ongoing supervision and support

3 Prevention, early recognition and early intervention are always preferred over a punitive approach in dealing with identified issues.

The saying "prevention is better than a cure" applies here. Being astute and responding to issues early prevents a situation escalating to a major incident.

When a supervisor encounters a clinician in difficulty, he/she should seek advice without delay. Experience has shown that simple interventions can be very effective if made early enough. Seek advice early from your line manager, other senior colleagues or workforce services department. Other units such as the employee assistant program and professional practice unit may also be of assistance to both supervisors and supervisees.

Example: Having a "crucial conversation" with a supervisee

You have noticed that a supervisee is having difficulty with workload management. You know this because you have noticed that he/she is frequently staying back to get work done, is often working though lunch and looks exhausted and overwhelmed. You are also taking note of the issues the supervisee brings to supervision and you are finding that the supervisee is taking on too much extra work. You suspect that the supervisee is doing "above and beyond" the work that is required because he/she does not understand their role and is therefore anxious about performance and unsure about boundaries. You decide to address this in the next supervision session. This entails having a 'crucial conversation' with the supervisee.

Steps in a crucial conversation

Setting the scene	Be transparent. Discuss and mutually agree upon what will be on the agenda for discussion.	"What would you like to discuss in supervision today?" "Because it has been such a busy time of the year, I would also like to take some time today to discuss workload management "
Discussing the evidence as a basis for your concerns	Focus on observable facts and behavioural evidence. Be constructive, timely and specific (see giving feedback on page 34).	"I wanted to share with you some thoughts about what I have noticed over the last few months"
Exploring the issues	Use active listening skills (empathy, questioning and open body language) and show genuine interest when trying to find out the cause of the issues.	"I am really concerned that you may be overdoing it at work. I have noticed that you are staying back late on a regular basis and often not taking lunch breaks. I am wondering what sort of an impact this is having on you?"
Looking for solutions/ support	Discuss strategies and support options to help address the issue. In this case it could be scheduling more regular supervision sessions, teaching time management skills or role playing how to say 'no' to requests made that are outside of role or scope of practice.	"My job as your supervisor is to ensure you are supported in all areas of your work. This means looking at ways in which we can help you to manage your workload"
Steps and timeline for improvement	Responsibility should be shared when looking for solutions. Mutually agree on one or two steps, strategies, solutions or support options that are realistic and achievable within a timeframe. Develop a SMART goal (see example on page 20).	"So we have agreed that over the next month we will meet once per week instead of once per fortnight. Let's make a time now for a session next week. For our next session, I will find some material for you to read in regard to workload management and you will keep a reflective practice log"

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Process for managing a staff member in difficulty

The algorithm below outlines a useful process to facilitate managing a staff member in difficulty.

Concern expressed about a staff member

Assess the severity:
- Patient safety?
- Staff member safety?
- Misconduct?

Preliminary assessment of concern

Consider potential underlying issues
Consider need for further investigation

Speak with the staff member

Listen and assess. Consider seeking advice from the line manager/Human Resources/Allied Health Director

Further investigation

Note findings. Consider referral to expert practitioner

Agree action plan and review date

Seek agreement of staff member
Document the action plan

Implement action plan

Ensure staff member is adequately supported

Review

Reach a conclusion. Is the matter resolved or does it require ongoing review or referral?

Source: NSW Institute of Medical Education and Training 2009, *Trainee in difficulty. A handbook for Directors of Prevocational Education and Training.*

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Part four

Appendices of useful resources

Appendix A

Supervision contract example

This supervision agreement is made between:

_____ and _____

(Supervisee)   (Supervisor)

We agree to the following:

The aim of supervision is to enable the supervisee to reflect in depth on issues affecting practice in order to develop professionally and personally towards achieving, sustaining and developing a high quality and safe service to patients of (organisation)

_____.

We will read, discuss and adopt the agreed organisational policy and guidelines on clinical supervision, if appropriate.

The time and place for supervision meetings will be protected by ensuring privacy, time boundaries, punctuality and no interruptions. Sessions will only be cancelled with good cause and an alternative/next date confirmed.

We shall aim to meet regularly as follows:

Frequency: _____   Length of session (approx.):_____

Sessions will be guided by an agenda and agreed to by both supervisor and supervisee but will contain time for ad hoc discussion and reflection where appropriate.

The content of supervision will not be discussed outside the session unless expressly agreed by both parties with the exception of unsafe, unethical or illegal practice being revealed.

Signed: Date:

(Supervisee)

Signed: Date:

(Supervisor)

Appendix B

Clinical supervision agreement example

Date of agreement	
Clinician	
Clinical supervisor	
Team leader	
Review date	

1 Clinical supervision will address the following areas:

_____

_____

_____

2 Clinical supervision will take the following form and frequency
(eg. 1:1 meeting, team meeting, peer shadowing):

_____

_____

_____

3 Confidentiality

Our understanding of confidentiality is that the content of support meetings is confidential between the parties, but where there are issues regarding clinical risk and/or performance management, information may need to be shared with other relevant parties.

Should information need to be shared, the supervisor will advise the clinician in advance of this occurring, including what information will be shared, with whom and for what purpose.

Other areas to consider:

_____

_____

_____

_____

_____

_____

_____

4 Record of clinical supervision

Who will record it?

_____

Where will the records be kept?

_____

Who has access to this information?

_____

What will happen to the clinical supervision notes when:

The clinician leaves their position?

Notes will be maintained/Archived in line with record management policies.

Additional information:

_____

5 Clinical supervision meetings (if applicable)

The clinician will prepare for each meeting by:

_____

_____

The clinical supervisor will prepare for each meeting by:

_____

_____

Should a meeting need to be rescheduled we agree to:

_____

_____

6 Other considerations

The details of this document can be modified at any time when agreed by both parties.

A copy of this agreement will be given to the team leader/line manager for their records

Signed:_____ Date:

Name: _____

Signed:_____ Date:

Name: _____

Source: Port Augusta Hospital and Regional Health Service, cited in Allied Health Clinical Support Framework, Country Health SA, SA Health, May 2009.

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Appendix C

Notes on supervision session example

Present: …………………………………………

Apologies: …………………………………………

Date:……………………………………………..

Topic	Discussion	Agreed action

Agenda items for next session	Preparation required

Signed _____   Signed _____

Date   _____   Date   _____

Source: Allied Health Clinical Support Framework, Country SA, SA Health, May 2009.

Appendix D

Supervision log example

Supervisee: Supervisor:

Date	Type/Length of session	Outcome

Source: Allied Health Clinical Support Framework, Country SA, SA Health, May 2009

Appendix E

Supervision feedback form example

This form is designed to help you, your team and the service as a whole to get the most from your clinical supervision.

Frequency of supervision sessions:

_____

Do you have an agreed documented supervision contract with your supervisor? Yes / No

Are your supervision goals and objectives being met?

Yes / No

In what way are / aren't these goals and objectives being met?

_____

_____

_____

What are the most useful aspects of your supervision?

_____

_____

_____

What expectations are not met from your supervision?

_____

_____

_____

Do you have any additional comments about your supervision?

_____

_____

_____

Source: Area Nursing and Midwifery Services Policies and Procedures, Clinical Supervision Policy 2007/01 cited in South Eastern Sydney Illawarra area procedure, Clinical Supervision – Podiatrists, September 2008.

Appendix F

Smart goal template example

SMART goals need to be Specific, Measurable, Achievable, Realistic and Timely (Doran 1981).

SMART goal:
Specific steps:

SMART goal:
Specific steps:

SMART goal:
Specific steps:

Reflective practice template example

Description - Describe as a matter of fact what happened during your critical incident or chosen episode for reflection.

_____

_____

_____

Feelings - What were you thinking and feeling at the time?

_____

_____

_____

Evaluation - List the points or tell the story about what was good and what was bad about the experience.

_____

_____

_____

Analysis - What sense can you make out of the situation? What does it mean?

_____

_____

_____

Conclusion - What else would you have done? What should you perhaps not have done?

_____

_____

_____

Action plan - If it arose again, what would you do differently? How will you adapt your practice in light of this new understanding?

_____

_____

_____

Source: Adapted from Gibbs, G. (1988) Learning by doing: A guide to teaching and learning methods. Further Education Unit, Oxford Brookes University, Oxford.

Appendix H
Supervision session outline example

	Agenda/structure	Content	Timing (approx)
1	Preparation	Supervisors and supervisees must prepare for a clinical supervision session. The supervisee has to consider what they want to focus on – preparing specific questions prior to the session will help focus thinking and reflection. ● Review notes on what was discussed in previous clinical supervision session. ● Review goals. ● Write notes about what to talk about in clinical supervision. ● Use support materials such as: reflective journal/ portfolio, case notes review, results of measuring outcomes, reflective statements.	Before session
2	Identifying & exploring	● Identify incident or area to focus on and explore/ talk over new issues. ● Reflect on issues affecting practice, caseload planning, decision making. ● Reflect on patient incidents or interventions (eg, assessment skills, counselling skills). ● Review what was discussed at previous clinical supervision session. ● Casework review - Presentation of a clinical issue or patient case by the supervisee.	10 mins
3	Analysing	● Clarifying, analysing, questioning, challenging actions/ideas and considering options. Discussion and feedback from the supervisor. The supervisor may use questioning to aid the supervisee's reflection and encourage them to reach new conclusions.	30 mins
4	Goal setting & action planning	The supervisor may demonstrate a particular treatment for a given situation or draw attention to a particular guideline or outcome measure and may suggest further information gathering through reading. Review of issues in conjunction with: ● Relevant theories ● Practice standards ● Quality indicators ● Developing ideas about how to incorporate EBP. Goal setting – problem solving and action plan to achieve goals. SMART goals (specific, measurable, achievable, realistic, timely). Link the discussion of goals to the last meeting. Assigning new issues to address. Identify short, medium and long-term goals and timeframes to achieve these goals - Tasks are identified to achieve goals.	10 mins
5	Summarising	Review the session, record and close. It is essential that an outcomes-based action plan is agreed upon at the end of each session. It is recommended that the supervisee records the learning outcomes and action plan from the session.	10 mins
6	Reflection in practice	Apply new information/skills/approaches to clinical practice. Ongoing reflection on practice.	Bring to next session

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Acknowledgements (continued from page iv)

Contributions and reviews were provided by many people, in particular:

| Name	Position	Organisation
Heather Gray	Chief Executive	HETI
Gaynor Heading	General Manager	HETI
Craig Bingham	Program Manager	HETI General Medical Training Unit
Rob Wilkins	Program Coordinator	HETI Centre for Learning and Teaching
Danielle Byers	Program Coordinator	HETI Centre for Learning and Teaching
David Schmidt	Rural Research Project Officer	HETI Rural and Remote Directorate
Elisabeth Ford-Conroy	Occupational Therapy Educator Prince of Wales and Sydney/ Sydney Eye Hospitals and Health Services	South Eastern Sydney Local Health District
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Notes

Notes

Notes

The Superguide

a handbook for
supervising allied health professionals

This is a user friendly handbook designed to assist allied health professionals who are responsible for supervising other staff.

It provides information about:

- supervising allied health professionals in ways that contribute to the safety and better care of patients
- effective methods of contributing to the education, welfare and professional development of allied health professionals

This handbook is not a policy document. It gives tips and suggestions based on the published evidence of what makes good supervision and the knowledge of many experienced allied health supervisors in New South Wales.

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